Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** PM 30 mnie 2010 Jonvary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memoria NIA Lnion Homore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F 43-16-425 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a, State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director attmore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Tarles by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 🕦 № Baltimore, Maryland 21215-0036 Blac If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ NO Specify. Specify: 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be am ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) buardian Bathmore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Desurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 2010 Baltimore 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Icense 22. Name and Address of Facility 4600 Mull 23a. Part 1. Enter the disease, or complications that caused #/e death. Do not enter the mode of dying, such as cardiac of respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEVTENSION **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical the as attending properties of IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Femur Fracture 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 1No 24 hours after death.
Funeral Director: After this certific stely filled in by the funeral director. 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 🗆 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Man r of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office huilding, etc. (Specify)

Nursing Home - ural 5 Pending investigation Subject fell. 1 ☐ Yes 2X No 01/30/2010 2X Accident 6 ☐Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2327 N. Charles St.,Baltimore,MD 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifie (Check only one) completely and manner stated the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35102 NMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North CHaules Dow m.D. 5901 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State FEB 0 4 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03002 State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:30A M January30,2010 R. Pellizzari /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sykesville Frinder 1 Year | If Under 24 Hrs. Carroll Transitions Health Care age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🛛 F 94 July10,1915 Pennsylvania Director 174-54-3334 Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Explaint or must be notified at 1 ☐ Yes 2 ☑ No Director Carroll Sykesville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 U.S.A. 110 Taft Terrace Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify.White 9 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker i 2 should be filed with and Mental Hygier
7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Regotti Antonio Orlandi ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar 27 110Taft Terrace, Sykesville, Maryland other t Rena Rhodes 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or one. N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HolyCrossCemetery 2-3-10 Jerome, Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Marzullo Funeral Chapel, P.A michael 6009Harford Road, Baltimore, Maryland21214 mar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lung Physician hronic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate I 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner' Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 4 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 6 the Hospital + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TARIQ NALTMOOD PIRCLE RE

State Registrar

(ARIQ

31. Date filed (Month, Day, Year)

MALTMOOD 32: Registrar's Signature MD 21157

Weitminister

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of Ma	aryland					and M	ental Hy	giene		
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	Examin	er	The Johns Hopkins Ho	Baltimore City							40. County of Beauti			
	Funeral Director		5. Social Security Number 6. Se 217–56–3290	7. Age	67	st birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da Dec • 2	th Y Year) 7, 19	9. Birt Co. 11	hplace (State or Foreign intry) reland
	D		Usual Residence of Decedent											10.11.00.10.00
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	ms 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S	. 13. V	Vas Dece	dent of Hi	spanic Ori	igin? (Spe	cify Yes or No	-	14. Race - Amer	
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8	ural",	d by	3 Widowed 4 Divorced	Year or Dates:		16a, Deced	lant'e Heu	al Occup	ation			16b Ki	ind of Business/	Industry
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Mar	12 sh hand 7 is m iraum		19a. Informant's Name/Relationship (T)				_						or Town, State, Z	
9	1 and 2 Health em 27 other tra		Christina Price  20a. Method of Disposition	<u>Daughter</u>	20b. PI	ace of Dispo	sition (Na	ne of			atonsv ate		, MD 21 ocation - City or	
מַ	Pages nent of h ant: If ite ury or of		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			emetery, cren antic				2/8/	2010	Glen	Burnie	, MD
Baltimore, Maryland	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licens	-0	0	1 22	. Name ar	nd Addres	s of Facili	tySter	ling A	shto	n Schwa	b Witzke
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ם מ	s afte	Cert	4   Homicide	building, etc	;. (Specify)						City of 10	vii, State)	,	
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	75		30. Name and address of person who			23a) (Type,	Print)			000				MD C400T
	1/2		100.	RINESINO 32. Registra		ıre 🌶	. 4			600 N	orth Wo	oite S	τ, Baltimo	ore, MD, 21287
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State State Registrar	of Marylan	d / Depa <i>Cer</i>	artment o <i>tificate o</i>	f Health and N f <i>Death</i>		giene 2   Reg. No.	0 1 0	03004	
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	Year	3. Time of Death	
F	Physicia Medic	al .		y, Jr.				Febru	ary Day , 2		6:55 P M	
	Examin	er	4a. Facility Name (If not institution, give street and r 2929 E. Monument Str				or Location of Death imore City		4c. Cour	nty of Deatl	n	
	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign	
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death	d stygene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Armed	ecedent Ever in U.S Forces?	S, 13. V	Vas Decedent of f Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Ame	rican Indian, e. etc.	
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9-10	ical E	lete	15. Decedent's Education	Dates.	16a. Deced	dent's Usual Oc	cupation		16b. Kind of	Business	Industry	
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7 with	ygiene her th t, the			4	Sale	esman	<del></del>			cail_		
	ed ot even	To Be	17. Father's Name (First, Middle, Last)  Robert Lee Rigney				18. Mother's Nan Margie			ıme)		
d pinc	mark maric		19a. Informant's Name/Relationship (Type, Print)		19h Mailir	na Address (Str	eet and Number or Rui			n. State. Zio	Code)	
She She	ulth an 27 is r trau	П	Robert Lee Rigney, Fa	ther			ter Avenue					
<b>a</b> lanc	item		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name or	place)	Date	20c. Locatio			
Page Page	ment ant: I		1X Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State Gr	een Hi	atory or other LI Ceme		5/2010				
Balt permit.	Department of Health and Mehral riggere.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once, in the manual process.		21. Signature of Funeral Service Licensee	. Harman			dress of Facility Water	renn-Ye , Danvi				
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<b>Vita</b> /sicia	s cert	To Be	examiner? Hospital:	☐ Inpatient 2 ☐	BR/Outpatie		Othor	iome 5 XRes	idence 6 🗆 (	Other (Spec	cify)	
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Division of Vital Records, P.O. Box 687 talor Attending Physician: The law requires that the death certifit	after o Direct I in by	Certificate:	4 Hamisida determined 286. P	ace of Injury - At h uilding, etc. (Specii		reet, factory, of	ice	28f. Location City or To	(Street and Nu wn, State)	mber or Hu	ral Route Number,	
Division of Vital Records, P.O. Box 68760 for the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the	he best of my know	vledge, death	occured at the	time, date and place, a	and due to the c	ause(s) and ma	anner as st	ated. cause(s) and manner stated.	
the H	hin 24 <b>the F</b> mplete	Me	only one) 3 Certifying Nurse Praction	ner: To the best of n	ny knowledge,	death occurred	at the time, date and pla	ace, and due to t	he cause(s) and	manner as	stated.	
, b	.∺ <b>.</b> ⊠		29b, Signature and tiple of certifier	M		i	ense number 067325		29d. Date sig			
			30. Name and address of person who completed	cause of death (Iter	m 23a) (Tvpe	Print)						
			Dr. Anitha Nallu, M.I				Baltimore,	MD 212	201			
	Sta Registr			2. Registrar's Sign								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** rebruary KAJAKAM 2010 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital N/A 8. Date of Birth
(Month, Day, Year) If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 - F Yrs. India 112-48-3005 74 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 XYes 2 □ No ms 23a or 28a-f s must be notified Director Maryland N/A Baltimore the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code with 1 United States Funeral 301 Warren Avenue Apt. 402 21230 Pages 1 and 2 should be filed within 72 hours after death 'natural", or items dical Examiner mu Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Saltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the Non-Profit Organization Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental H 27 is marked ot traumatic even Ramanathan Rajaram Kamakshi unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Chandra Ramanathan/ Wife 301 Warren Avenue Apt.402, Baltimore, Maryland 21230 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 4. ţ 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department or Important: If any injury or once. ± 5 Metro Crematory, Inc. 2010 Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Ligensee Alice Iser 301 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CELL LUNG CARCINOMA **Physician** NON-SMALL year 4 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 2 No d by the al 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 4 Unknown DIABETES MALLITUS 1 TYes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy performed? Yes 2 No a No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Vinpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide Hospital 24 hours 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor.

To the Funer

completely fill Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAILENDRA SINGH

FEB 0 4 2010

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



and manner stated.

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

2010

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES - 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 9:00 A.M Ina E. Ross February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Charlestown Dorsey Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. (Month, Day, Y March 30 Days 1 M 2 5 F Pennsylvania 214-22-8019 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street of is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at Director Catonsville 1 Yes 2 X No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21228 719 Maiden Choice Lane HR325 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Specify: White þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Myrtle Campbell Samuel Engle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
719 Maiden Choice Lane HR325; Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) Husband Carl E. Ross 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 
Burial 2 
Cremation 3 
Removal from State Glen Burnie, MD 2/5/2010 Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ leaks disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital 1 🗆 Yes Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury a 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier Tobruany

State Registrar 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 16b per fh. \$900 2-4-10 yr. State of Maryland Poepartment of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ 2010 JUDITH MARIE RUCKEL 6:15 amM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8484 Imperial Drive Laurel Prince George's 8. Date of Birth (Month, Day, Aug 2, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Days Hours Months 1952 Missouri Yrs Director 212-62-1893 57 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 XXVo MD Prince George's Laurel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Examiner must be Funeral U.S.A. 20708 8484 Imperial Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14, Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.] Black. White, etc. 1 XXvever Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: 3 Divorced 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) Printer Fodral Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George C. Ruckel Kathryn Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Nancy Fontaine / sister 8484 Imperial Drive Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 9 1 Burial 2XXCremation 3 Removal from State injury ( West Arundel Crematory 2/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707 21. Signature of Euneral Service Licensee /M00770 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inly one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. Lis Interval Between Onset and Death Immediate Cause (Final Physician/ Diabetc. disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 2 Yes 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Investigation Accident the 3 Suicide 4 Homicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie 1, 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10710 Charter Drive, Suite 410 Columbia, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	Maryland / De <i>C</i>	partment of I ertificate of			iene <sub>eg. No</sub> 2010	03008
			1. Decedent's Name (First, Middle	, Last)				2. Date of Death		3. Time of Death
	Physici /Medio		Frederick	J.		Rogers		Februar		1:24 A M
	Examin	er	4a. Facility Name (If not institution		er)		or Location of Deat	h	4c. County of De	
	F		40 Lombardy Dri 5. Social Security Number		Age (In yrs. last birthda	Dund	If Under 24 Hrs	8. Date of Birth	Baltimo	rthplace (State or Foreign
	Funeral Director		219–36–1079	1 <b>X</b> M 2□ F	66 Yrs	Months   Davs	Hours Min.	July 13	,1943 Mai	cyland
	pr ,		Usual Residence of Decedent		10c. City, Town or	Location				10d. Inside City Limits
	shov	'n	10a. State 10b. County	marc		ndalk				1 ☐ Yes 2 No
	the M	rect	Maryland Balti 10e. Street and Number	поте	Dui	10f. Zip Code		1-	0g. Citizen of What C	country?
	3a or	Funeral Director	40 Lombardy Dri	ve		2	1222		USA	
	death	nera	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	Specify Yes or No-	14. Race - An Black, Wh	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinet must be notified at	by Fu	1 Never Married 2 Marr	ied 1 □Yes 21 If Yes, Give	⊠ No	1 □Yes 2 ☐XNo		,		White
21215-0036	hours fural	ed p	3 ☐ Widowed 4 ☐ Divorced  15. Decedent	Year or Date		cedent's Usual Occu	pation		16b. Kind of Busines	s/industry
215	e. In "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)		life	ive kind of work done e. DO NOT use retire	during most of wo ed)	rking		
21	d with rgiene er tha	l E	12 years	January College (1 40	N	Maintenanc			General M	Motors
pui	be file Ital Hy d oth event	Be	17. Father's Name (First, Middle, Edward Rogers	Last)				<sub>me (First, Middle, M</sub> aret Jaco		
ryla	d Mer narke	ဍ		hin (Timo Print)	10b M	ailing Address (Stree			, City or Town, State	Zin Code)
Ma	d 2 sh Ith an 27 is r traur		19a. Informant's Name/Relations Gladys Rogers	wife		Lombardy_			•	1222
re,	s 1 ar if Hea item 2		20a. Method of Disposition		20b. Place of Dis	sposition (Name of rematory or other pla	T1-1-		20c. Location - City of	
E	Page nent o int: If iry or		1 ☐ Burial 2 🂢 Cremation 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>			Crematory			Baltimore	, Maryland
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any jujury or other traumatic event, it a Wodical Expriner must be notified at once.		21. Fighture of Furtiral Service	Licensee	elly	22. Name and Addr Connelly 7110 Soll	ess of Facility Funeral I ers Point	Home of D t Road, D	undalk,P. <i>h</i> undalk,MD	A. 21222
		- 3	23a. art 1. Enter the diseas r shock, or heart failure.	complications that cause on each	sed the deal Do not h line.		ing, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
5	Physician		Immediate Cause (Final disease or condition	_a_ //	et as	fatre /	work	le Car	SER	Offiser and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	,				
		er	Sequentially list conditions, if any, leading to immediate	b Due to (or	as a consequence of):					
/	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissass of India) that initiated events	С.						
oʻ	icate be executed physician and s the burial-transit	EX	resulting in death) Last		as a consequence of):					
8760,	cate b	dical		d		——————————————————————————————————————				
9 X	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregnancy				23d. Date of d	lelivery
Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnar	nt at time of death	3 ☐ Ectopic pregnar 5 ☐ Other <i>(specify)</i> .	ncy		Month	Day Year
P.0		hys	9 Unknown	9 ☐ Unknow						
Vital Records, I	sign sign	þ	Part II. Other significant condition	ons contributing to deat	th but not resulting in th	e underlying cause g	iven in Part I.	23e. Did tol		to the cause of death?  Probably 4 Unknown
eco	e law requ has been ie 2 shoufc	Completed						24a. Was a	sy prior t	autopsy findings available o completion of cause of
- B	Th	Som						perform 1 □ Yes	med? death 2 No 1 □ Y	? es 2□No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		100	thor:	eath (Check only on	,	
o	Phys this ral dir	۱ <u>۲</u>	1 Yes 2 No	1 ☐ Inp	natient 2 ER/Outpa	illent 3 DOA	4 🗀 Nursing		ence 6 Other (S) ow injury occurred	pecify)
on	Attending F r death. sctor: After by the funer	tion	Pendin 2 ☐ Accident investig	g (Month,	Day, Year) Inju		orḱ? ⊡Yes 2.⊡No		• •	
Division	of or Attency after death Director: d in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	inod   Zoe. Place of	Injury - At home, farm, , etc. <i>(Specify)</i>	street, factory, office		28f. Location (S. City or Town		Rural Route Number,
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier  (Check only one)  Check only 2 Medical	ng Physician: To the be Examiner: On the bas and manne	is of examination and/o	eath occurred at the r investigation, in my	time, date and place opinion, death occ	ce, and due to the courred at the time, co	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
l	To th withir To th	Me	29b. Signature and title of certifie	All	rel 14	29c. Lices	2683	A	29d. Date signed (Mo	
			30. Name and address of person	who completed cause	of death (Item 23a) (Ty	pe, Print) Ra	etimore	me	7/3/2	2/204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		gistrar's Signature	barres			,	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Item 26 per verb., g900, 02703/2010dhb
State of Maryland / Department of Health and Mental Hygiene 2 (Certificate of Death Reg. No. 03009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Month Milton Physician/ 8:174 M Randall, Jr. 2010 Tanuan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5412 Clover altimore Koad If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Yrs. . Social Security Number **Funeral** 1 XM 2 □ F Months 212.42.7398 Director Usual Residence of Decedent permit. P. ge 1 and 2 should (e filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is married other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral Clover 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Black 1 ☐ Yes 2 X No Specify. Specify: 3 - Widowed 4 - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Baltmare City (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Sanitation Machinist Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wallace Milton Randall, Sr. Gertrude 19a. Informant's Name/Relationship (Type, Print)

Brenda C. Randall/Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clover Road Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ➤ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 01/30/10 Western Star 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Voughn C. Greene Funeral Suco iberty Road Randallstown MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 hcs Peritonitis Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) 2ites requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law cate has page 2 s autopsy certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospital: 2 No 1 🗌 Yes SER/Outpatient 3 ☐ DOA မ 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 nd title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greene St. Balt MP 20201 MP Donna Hanes 2010 32. Regis ar's Signature JAN 25 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **February** 2010 10:40 a M Margaret Dunkley Stuart Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda 9. Birthplace (State or Foreign Country) Districtor Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, April 5 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months **Director** 577-44-2303 Columbia Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Maryland | Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20815 5100 Dorset Avenue #114 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Richard Dunkley Margaret McKinley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health s Important: If item 27 is any injury or other tra Gray W. Stuart/ Husband 5100 Dorset Avenue #114, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 3, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facili@remation Society of Maryland, Inc. Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Bowel Ischemia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate Yes 2X No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes မ 2 😾 No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 🗶 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the To the 29c. License number 066066 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who comp eted cause of death (Item 23a) (Type, Print) nden wong, mp 8600 Old Georgetown Road, Bethesda, Maryland . Registrar's Signatu State Registrar

01/1/2

MORGONET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Pe-a 2. Date of Death 3. Time of Death DOROTH Month Physician/ 013-1AM Medical 4a. Facility Name (if not institution dive street and number) . City, Town, or Location of Death Examiner 4c. County of Death RAIL: MOTO naver DUINE BAITIMOTE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 W March 4 1920 Balt. Maryland 214-14-0181 Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore Baltimore Maryland 1 Yes 2XNo 10e. Street and Number 10f. Zip Code Onited States 21236 Funeral 35 Belhaven Drive of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 25 No Specify: White 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant; If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetics Cosmetician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kathryn King Ferdinand Schilling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Bonnie Oliverio/ daughter 207 Bayview Lane Unit #207 Ocean City, Maryland 21842 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot February 2, 1 Burial 2XX remation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Juneyal Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 22K10U2 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine If any, leading to introduce cause. Enter Underlying Que to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed After this certificate 25 25. Was case referred to medical examiner?
1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗌 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated criffying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) MAGNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St.

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 1° 2010° Lorne Schnurr, Jr. 2:25 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 28, 1 🔀 M 2 🗆 F Months Days Hours Mary Land 199-24-8911 82 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Tes 2 No Maryland Harford <u>Jarretts</u>ville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral United States 4053 Norrisville Road 12. Was Decedent Ever in U.S. Armed Forces? 1950-13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or ite Black, White, etc. þ 1 Never Married 2XXMarried 1 ★ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1951 1 ☐ Yes 2 ➡ No Specify Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Farmer Farming e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other in other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lorne Schnurr, Sr. Florence Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4053 Norrisville Rd. Jarrettsville, Maryland 21084 19a. Informant's Name/Relationship (Type, Print) Daisy E. Schnurr / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. Date 9. 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: It any injury or once. Highview Mem. Gardens 4 Donation 5 Other (Specify) 2010 Fallston, Maryland 21. Signatur of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-BelAir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cordiar disease or condition resulting in death) udden Medical Due to (or as a consequence of) Examiner Requestially list aunditions Be Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) al or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and as the burial-transi olonary aftery that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a Was an cate has l autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No Other: ျပ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Marse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifier 0057223 20/0 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre

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Registrar

DHMH 17 Rev 7/2009

State

### **VOID**

# CERTIFICATE #

2010 - 03013

# SEE

**CERTIFICATE #** 

2009-45600

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Physician Medical Examine	1/	1. Decedent's Name (First, Midd Frederick S	<sub>lle,Last)</sub> chmidt		·			Month	January 30, 2010				
		4a. Facility Name (if not instituti Northwest Hospital E			4	b. City, Town, o Randallsto		Baltimore Count					
Funeral Director		5. Social Security Number 214–46–6008	6. Sex 7. Ag	e (In yrs. last bir	1943	Foreign	nplace (State or n Intry) NC						
ow any	-	Usual Residence of Decedent  10a. State 10b. County  MD Balt	imore	10c. City, Town		on						10d. Inside City Limits 1 Yes 2 No	
e Maryland or 28a-f sh.	Director	10e. Street and Number 2676 W. Park		Gwyiiii	Uak	10f. Zip Code	207			tizen of Wh	at Coun		
	— L	11. Marital Status 1 Never Married 2 X	12. Was Deceden Armed Forces  1 Yes 2					? ( Specify Yes or Juerto Rican, etc.)	No-	14. Race White		an Indian, Black,	
tours after d	⋧┞	15. Decedent's Education (Spe	vorced If Yes, Give Year or Dates: ecify only highest grade cor	mpleted) 16a	Decedent	Yes 2 X No	ation (Give kin		16b.	Specify: Kind of Bu		ndustry	
0036 within 72 h giene. ner than "n Medical E	Completed	Elementary/Secondary (0-12 12		5+)		abled		·	e (First, Middle, Maiden Surna				
1215- be filed antal Hyg irked oth	Otto Freddie Schmidt Rosa Lee								gani	ous			
AD 21 2 should h and Me 27 is ma matic en	2	19a. Informant's Name/Relation David Gurgani						er or Rural Route N en Burnie				Zip Code)	
more, hades I and ages I and of Healt of Healt of: If item	Ī	20a. Method of Disposition  1 K Burial 2 Cremation 3 Removal from State  3 Donation 5 Other Specify:  Meadowridge Mem. Park  20b. Place of Disposition (Name of cemetery, crematory or other place)  Meadowridge Mem. Park  2/10/2010 Elkridge,											
Baltil permit. 1 Departm. Importa	1	1. signature of Funeral Service	a Licentiee	they	22. N Fur 1163	ame and Addres	s of Facility ome of dson A	Sterling Catonsvi venue: Ca	Ash lle,	ton So Inc.	chwa e. M	b Witzke D 21228	
Physician Wedical Examiner		23a. Part I. Enter the disease, c failure. List only one causi Immediate Cause (Final diseas or condition resulting in death)	é on each line. e a. <mark>Atherosclerotic</mark>	Cardiovascu			, such as card	diac or respiratory	arrest, sł	nock, or hea	art	Approximate Interval Between Onset and Death	
	_	Sequentially list conditions, b.											
p is	Examiner	caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		***				_					
an and and and and and and and and and a	Medical	UNPENDED	d AMENDED										
Box 68760, e death certificate be the attending physicied for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	4 Pregnant a		2 Fet	al death 3 ner (Specify)	Ectopic p	eregnancy	2	3d, Date of Month		ay Year	
hat the deed by the detached for	by Phy	Part II. Other significant cond	9 Onknown	h but not resultin	ig in the u	ndertying cause	given in Part			o use contri		he cause of death?	
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n of Vit ding Physici After this of funeral dire	on: To B	1 Yes 2 No 27, Manner of Death	Hospital: 1 Inpati		Outpatient Time of Ir	njury 28c. Inj	Other of the other	Nursing Home 5		njury occurre			
Division of Vital Rector to the Hospital or Attending Physician: The lawibin 24 hours after death.  To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification:	2 Accident Inv	estigation	njury - At home, f	arm, stree			2Bf. Location	n (Street n, State)	and Numbe	er or Rui	ral Route Number, City	
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier 1 Certifying I	Physician: To the best of n aminer: On the basis of exa and manner stated	ny knowledge, de amination and/or	ath occur investigati	red at the time, o	date and place in, death occu	e, and due to the ca	ause(s) a ate and p	and manner place, and d	as state ue to the	ed. e cause(s)	
F 3 F 8	Me	29b Signature and title of certif					se number			nuary 31		ith, Day, Year)	
3	ļ	30. Name and address of personal Margarita Korell MD.	n who completed cause of Assistant Medica		111 Pc	enn Street, E	Baltimore,	MD 21201					
Sta	te	31. Date filed (Month, PRY)	4 2010 32 Delistr	er's Signature.		VE -							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#26perDVR, G900, 2/4/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January SNYDER 2 54 A M LEW **EDWARD** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🕱 M 2 🗆 F 74 July 24, Year 1935 Maryland Director 220-28-8345 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 귫 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Mt. Airy Carroll Maryland 1 ☐ Yes **XX**No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 713 Midway Avenue 21771 USA ral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
Yes 2 [
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes XX No Specify: Specify white 3 Divorced 4 Divorced Year or Dates item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction tile setter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ not known Isabel Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Snyder - daughter P. O. Box 326166, Agana, Guam t: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 
Burial 2 Cremation 3 
Removal from State Important: It any injury or 2-9-2010 **Department** Stauffer Crematory 4 Donation 5 Other (Specify) Frederick, Maryland of Funeral Service License 21. Signatu 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ■ No 24a. Was an autopsy Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 D No Other: Certificate: To 1 Yes 1 Inpatient 2 KER/Outpatient 3 DOA 4 Nursing Hon Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? Natural 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 🥌 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: The pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature FEB 0 4 201 State 0 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 7:00 PM el Hannah Sussman 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County Pikesville Sunrise Senior Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7 Age (In vrs. last birthday) **Funeral** Months Days New York, NY 1 M 200 1915 May 14, 94 107-07-7058 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 1 ☐ Yes 2 ☐ No 28a-f sh notified Pikesville Baltimore County Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or Sunrise Senior Living Pages 1 and 2 should be filed within 72 hours after death with USA 21208 3800 Old Court Road 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes ¾√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: þ 3☐Widowed 4☐Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than "natu vent, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School System Secretary 4 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yetta Scheer 27 is marked of traumatic even Louis Herman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21209 2104 Smith Avenue Health item 27 i Mark Sussman Department of Health Important: If Item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 2/9/2010 N. Lauderdale, FL Star of David Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc 21. Signature of Juneral Service Licenses Baltimore, Maryland 21211 3631 Falls Road Approximate Interval Between Onset and Death te, or complication: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cluse on each line. art1. If ter the dise se, STAGE Chronic obstructive WilmonA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine The law requires that the death certificate be executed TENSION to (or as a consequence of) physician a s the burial-1 Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Month Day 4□Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a Was an ate has bade 2 s autopsy performed? Yes 2 Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred after death.

I Director: After to d in by the funera Certification: 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral [ filled 🛢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) \$32. Registrar's Signature

FEB 0 4 2010

Name and address of person who completed caus

DHMH 17 Rev 1/2001

ReDerkt Md 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 1 per doc 2900 2-16-10 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Donald Griffiths 2. Date of Death Secor Physician/ February 2, 12:30 PM David Griffiths Secor 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville 8 Westbury Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** New York Months Days Hours 5/10/1922 1 □**X**M 2 □ F 056-12-3791 Director 87 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director notified 28a-f Baltimore Lutherville 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 21093 USA 8 Westbury Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give WWII/Korea 1 Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Analyst (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NSA the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental He tant: If item 27 is marked ot ည Minnie Sophia Pruner Isaac Austin Secor other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Westbury Road Lutherville, Maryland 21093 David B. Secor/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State <u>+</u> 5 1 Burial 2X Cremation 3 Removal from State Department c Important: If any injury or 2/4/2010 Hilltop Serv. Corp. Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Coronary Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) lears Medical Due to (or as a consequente of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsv perform death? rmed? 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

To the within 2 To the F

Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number D 000 32548

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department 9619601 Our Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sherman Leon Smith 21 2010 4c. County of Death /Medical Jan 5:05p 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 5515 Gerland Ave. Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jul. 28, 1953 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 ☑ M 2 □ F 56 MD 215-60-7382 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD ral", or items 23a or 28a-f sh Examiner must be nutified Baltimore 1 SyYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5515 Gerland Ave. 21206 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Balto. City Teacher permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important: If item 27 Is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles O. Smith Violet Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Jenkins 513 Country Ridge Cir. Belair, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Western Star Cem. 1/28/2010 Baltimore, MD 22. Name and Address of Facility Wesley Chavis, Jr. FH 21. Signature of Funeral Service Licenses 2007 Eastern Ave. Balto. MD 21231 25 r complications that soused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, that only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis shock, or heart failure. Immediate Cause (Final AR **Physician** disease or condition resulting in death) /Medical or as a consequence of TENSION Examiner PER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events activities in dooth). Examine law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medica! IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐No ff Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform i∐Yes 2**X** No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3100 Ste # 108 LoveD YOUR DR BAITIMORE A. ANYW 2124 JOSEPH

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ January Day 8, 2010 10:20aa Ruth Shelton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick Villa Nursing Home Catonsville Baltimore 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 01/06/ Maryland Months 71 1939 **Director** 213-36-5094 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Ves 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 422 S. Stricker Street 21223 LISA hours after death 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed with and Mental Hygier. Is marked other the 0 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Raleigh Kenneally Mary E. Kurtz of Health and Mer of Health and Mer fitem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan D. Vukovan / Sister 422 S. Stricker Street, Baltimore, Maryland 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State Ravview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2/1/2010 Baltimore, Maryland 21 sig atur of Funeral Service Loense 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. On et and Death Immediate Cause (Final Ph sician/ Prieumoni disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami The law requires that the death certificate be executed and trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death
Unknown Day g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ o, Diabetes, Hypertension 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗌 No 1 🗌 Yes Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this hin 24 hours after death.

the Funeral Director; After thi

mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier (Check within 2 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

vita 31. Date filed Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brown 7994 Silent Winds

29d. Date signed (Month. Dav. Year)

Apt I Gen Burnie MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 9:08 PM harles Curtis February Siebert 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Havre de Grace Harford Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland Social Security Number . Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F Yrs. 62 Director May 14, 1947 217-46-1763 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprising in ast be notified at 1 ☐ Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 840 Gilbert Road 21001 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No 1966— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2XX No Specify: White 1972 3 ☐ Widowed 4X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 laborer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) F. William Siebert Joanna Morris 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. William Siebert (father) 840 Gilbert Rd., Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/10 Churchville, Maryland Calvary Cemetery 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** Acute /Medical Examiner Syery cronary Arteny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) bronic Obstructive sician and burial-tran Due to (or as a consequence of): 30 year Physician/Medical Lobacco 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ► R/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the I within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MD 1,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

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Ave HAURE de GRACE, MD 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Konald a: Fam menunson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joseph Ritchie Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Hours 05/25/ Director 217-32-7791 72 1937 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2810 Presbury Street 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 A Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Maintenence Engineer Taxtrol Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Thompson Naomi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Thompson Jr. (Son) 9845 WinandsRd, Randallstown, MD 21133 20b. Place of Disposition (Name of Josephery, crematory or other place), H And Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 02/04/10 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 Unknown cate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 🗌 Yes 2 No 3 Probably 4 Unknown Thrive 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy the Hospital or Attending Physician: The After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 Inpatient 3 Inpa HOSDICT 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar Linden Av . Balt.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03022 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mildred Physician/ Virginia Turner January 2010 0705 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign Country)
Wash DC 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 223-50-5662 1 □ M 2**X** F Months Days Hours Min 06-07-1937 72 Yrs **Director** Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PG 1 🌠 Yes 2 □ No Marlboro Upper 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 500 N Harry S. Truman Dr. #312 20774 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3X Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Private</u> Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Norman Pinkney Melissa Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia R. Turner/ Daughter 5907 Kst #1 Fairmont Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o' 1 Burial 2 Cremation 3 Removal from State Heritage Memorial Pk 02-06-2010 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licensee 22. Name and Address of FacilityRonald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Metastatic Uterine Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a consequence of): -transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown the detached 9 Unknown P.O. ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Unknown 1 Yes 2 No 3 Probably Completed certificate has been si rector, page 2 should I 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 ည ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Data of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined ledical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certif ing Nurse Prac ioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sia title

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

FEB 0 4 2010

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 6:34 РМ Alexander Traska January 27. 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 19403 Burnside Bridge Road Washington Keedysville Keeuysviiic

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day, Year) | 9. Birthplace (State or Country)

APRIL 22, 194 | 0 UKRAINE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funera! 1**X** M 2□ F 220-36-0333 69 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Important: If time 27 is amended other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Medical Eventual to nother traumatic event, Ira Medical Eventual to nother traumatic event, Ira Medical Eventual to 1 10a State 1 ☐ Yes 2 XNo Director MD WASHINGTON KEEDYSVILLE 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 19403 BURNSIDE BRIDGE ROAD 21756 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: þ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOOD INDUSTRY CHEMIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TRASKA ANTIN OLHA STRONSKA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21756 19a. Informant's Name/Relationship (Type. Print) IRENE TRASKA/ WIFE 19403 BURNSIDE BRIDGE RD., KEEDYSVILLE, MD Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ST. MICHAELS UKRAINIAN 2/1/10 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun Name and Address of Earlier INC. FUNERAL HOME 901 EASTERN AVENUE, BALTIMORE, MD 1901 21231 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic years Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner faile Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) ed by the a detached f 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

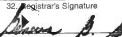
Division of Vital Records,

State Registrar

TAM 31. Date filed (Month, Day, Year) FEB 0 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier-



Thomas

29c. License number

29d. Date signed (Month. Day. Year)

Drive Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $P^{M}$ Van Santen February John Henry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1651 Wickham Way Crofton Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 □ F Aug 2, 1926 Months Days Hours Min 83 Ohio Director 288-20-9809 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Montgomery North Bethesda 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6501 Windermere Circle 20852 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural", Specify: White 3 XWidowed 4 Divorced Completed Year or Dates. 1944-66 Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the United States Army Lt. Col Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve မ John Henry van Santen, Sr. Hattie Doekes permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth L. Schrader/daughter 1651 Wickham Way Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 😾 Cremation 3 🗆 Removal from State Final Journey Crematory 2/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Sign were of Funeral Service Licensee any in Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician umonia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) dayghter's Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5  $\square$  Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar

15+1

308

30. Name and address of person who completed cause of death (Item 23a) (Type (Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Physician 4:00 PM arie Tebruai ,2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hmore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Nov. 13. 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 □ M Director Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. Cify, Town or Location ir than "natural", or items 23a or 28a-f show 1 Dyes 2 No Completed by Funeral Director 7008 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry سون within مند. من Mental Hygiene. T 7 is marked other than "n Traumatic even" Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 380 permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra 40 Baltimore, 20b. Place of Disposition (Name cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 Removal from State to more 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of rying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of pacity line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical as the l IF FEMALE: nse If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month be detached for Year Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? hash 24a. Was an perform this certificate 2 1 NO 1 □Yes or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 Tho Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man - of Death funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 THomicide within 24 hours a the Hospital 1 C, tilying Physician: To the best of my knowledge, it is considered at the time, date and place, and due to the cause(s) and manner as stated. 2 Examiner: On the basis of examination is for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year) e of certifie 29c. License number

State Registrar 31. Date filed (Month, Day, Year) 32 Regist

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM# 10b, perFH, G900, 2/4/2010, WS
State of Maryland, Department of Fleatin and Wental Hygiene
AMEND THEM# 20b, perFH, G900, 2/24/2010, WS

Certificate of Death

Reg. No. 2 | 1 1 - For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEB 25RA/DINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MAL TIMORE N 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 6. Sex -7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 M 2 F Director Usual Residence of Decede 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show Baltimore injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 ☑No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: à 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If frem 27 is marked other than any injury or other traumatic event College (1-4or 5+) Elementary/Secondary (0-12) ASHIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JANICE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 24-2010 20a. Method of Disposition PANDA/STAIN
PANDA/ 1 Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation ∮ □ Other (Specify) 21. Signature of Juneral Service Licon here Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate ause (Final disease or condition resulting in death) DEMENT Physician 2hermER 15 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CAPDIOVASCUL 2 No 3 Probably 4 Unknown 1 🗆 Yes MYPERTENSIVE completely filled in by the funeral director, page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed Vas 2 No has certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t Matural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident 24 hours after deatl Funeral Director: 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03 2010 M.D D0039107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 DRIVE BUSINESS CENTER UMA FEB 04 2010 Lineur S. Aarle ORIGINAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \_ State Certificate of Death Rea. No. Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 150 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TTO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 (Month, Day) Country) 5 1 🗆 M 2 📈 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director NA Examiner must be notified 1 Yes 2 □ No "natural", or items 23a or 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) reld Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider, ဂ္ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, .2/21 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of ☐ Burial 2 Cremation 3 ☐ Removal from State 4-2010 🗌 Donation 5 🗀 Other (Specify) 21. Sign ature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Plot 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 4 disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No Hospital or Attending Physician: The law requires 3 Probably 4 Unknown 1 Yes Records, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed after death.

Director: After this certificate h 2 Z No 1 Yes 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) V 5 Pending Vatural 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gladys B. Whye 2:05 Feh 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson 281 Hendrickson Lane 8. Date of Birth (Month, Day, Yea Jan. 18 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 M 2 F Months Hours Min. Country) 220-14-2337 **Director** 92 918 Georgia Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director MD Baltimore Towson 1 Yes 2 No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a of the Medical Examiner must be Funeral 292 Eudowood Lane 21286 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: Black XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry th and Mental Hygiene. 27 is marked other than ' traumatic event, the Me Elementary/Seconday (0-12)
7th Grade College (1-4 or 5+) Domestic Private Homes Engineer Be filed Department of Health and Mental H
Important If item 27 is marked oft,
any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel McNair Georgia Grigor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys J. Whye/ Daughter 281 B Hendrickson Lane Towson, MD 21286 Baltimore, 20b. Place of Disposition (Name of cernetery, crematory or other place) 2 / 9 / 1 0 Date Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State St. Luke U.M. Ch. Cem. Monkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Chatman-Harris Funeral Home Signature of Emeral Service Licens 5240 Reisterstown Rd Baltimore MD 21215 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown has been signed by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha irector, page 2 performe Yes 2 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 욘 After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending 1 Natural within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Aractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV MOITAMMED AHMED

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 4 2010

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G900, 274, 2010, WS
State of Maryland / Department of Health and Mental Hygiene 2 | | | 03029 For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ =25 A Medical give street and number, 4a. Facility Name (if not institution **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗹 F th, Day, Year 23 Country) MARY LAND Months Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? UNITER Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced Specify: MHU Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည or Rural Route Number, City or Town, State, Zip Code) MARY LAND 19a. Informant's Name/Relationship (Type, Print) NOTTINGHAM 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ARDENS OF FAITH CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee PARKVULE, MD - CREMHTT Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULLMONARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 OYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy perform prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 2 No ၉ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending a er death. 2 🗌 No Accident Suicide Director A Investigation Accide...
Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral Di completed filled in Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier FEBRUARY 2, 2010 30. Name and address ss of person who completed cause of death (Item 23a) (Type, Print) DANIEUE RMAN. MD SUITE 4105 PALTMORE, MS 21204 31. Date filed (Month, Day, Year) 22. Registrar's Signature State FEB 0 4 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Woods Corvary **Physician** 47 am /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** General Hospitai Under 24 Hrs 9/ Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F Months Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene, introduction in thems 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 1 Yes 2 □ No Funeral Director mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 2 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 nent of Health and Mental မ 19a. Informant's Name/Relationship (Type. Print) (grand Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a M 70 00% 20b. Place of Disposition (Name of cemetery, crematory or other place) Location - City or Town, State 20a. Method of Disposition Date 20c 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State S22. T92 21. Signature of Funeral Service Licensee 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. WINDETTA Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown care nas been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 12 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 1 2 No 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? examiner?

1 Yes 2 No

27. Manner of Death
1 Natural
2 Accident Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 【 ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation or Attending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basic of examination and/or investigation in accordance and the cause of examiners are caused as the cause of examiners and the cause of examiners are caused as the cause of examiners and the cause of examiners are caused as the caused as the caused are caused 29a. Certifie completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title

of certifier

- Ambalavanar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(845

Oak

29c. License number

wood Road

D51596

29d. Date signed (Month, Day, Year)

ColenBurnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:31 A M **Physician** ETHEL WILLIAMS 28 61 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** OF MARYLAND MEDICAL CENTER CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day. B. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** South Months 1 □ M 2 💢 F Carolina Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be restlined at 1 Yes 2 No Funeral Director mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by ac 3 Widowed 4 □ Divorced Decedent's Usual Occupation
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Department of H
Important: If ite
any Injury or ot
once. 1 M Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 22. Name and Address of Facility 21. Signature of Funeral Service License Home P.1 Bal W. North Ave. Approximate Interval Between Onset and Death 23a. Part / Enter the disease or complications that caused to shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) BRAIN **Physician** HERNIATION /Medical Due to (or as a consequence of) Examiner LYMPHOMP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician s the burial Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a 2 No o 9 Unknow ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 2 No 3 Probably 4 Unknown BACTELEMIA 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe 2 PNo certificate 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier LAMOS 118156 MD 2010 amo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar LAMOS

22

ELIZABETH

31. Date filed (Month

ST.

BACTIMORE

21201

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GREENE

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January 2010 9:55 P. Warch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice Of Chesapeake Linthicum <u>Arundel</u> <u>Anne</u> 8. Date of Birth (Month, Day, Year) 10-13-1932 Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. Mary Land Director 219-28-0777 77 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 900 Rosedale Avenue 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 A Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 🗌 Widowed 4 🗆 Divorced Specify: White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Franklin Warch Mary Agnes Dwyer 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen M. Paul / Daughter London Drive Lima, Ohio 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 02-05-2010 Elkridge, Maryland 21. Si na ry of Funeral Service Lice see 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.
1411 Annapolis Road Odenton, Maryland Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) noconcinoma Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine Ducito (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospice House examiner? 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

12

State Registrar

DHMH 17 Rev 7/2009

NL

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1412



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MO

29d. Date signed (Month, Day, Year)

#### 10-00944

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Charle	es Allen Wo		- For State	Stat	e of Maryla	nd / De	epart Certii	ment of ficate of	Health Death	and	Menta	ıl Hyg		g. No.	201	0	03033
	Physicia	R	legistrar 1. Decedent's Name	(First, Middle,L	ast)								Date of Death Month	Day	Year		ne of Death
P"	al Examir	ner	CHARL	ΞS	ALLEN		W	OLFE	Ib City To	um or lo	veation of		February 2	, 2010	County of Dea		45 1115
			4a. Facility Name (if		nd number)  4b. City, Town, or Location of Rosedale							- 1	altimore Co				
	Funeral		5. Social Security N		Sex	ex 7. Age (In yrs. last birthday)			If Under 1 Year If Under 24Hrs.			_	8. Date of Birt	DD/YYYY) 9. Birthplace (State or Foreign			
	Director	- [	216-52-	1922	<b>∑</b> M 2□F			59 Yrs	Months	Days	Hours	Min.	1-29	-19	51 °	Country)	MD
		L -	Usual Residence of			100	City T	own or Locat	on							10d. I	Inside City Limits
	ow any		10a. State MD	10b. County BA	LTIMORE	l	O.J.			SED	ALE					1 [	Yes 2 No
	uryland Sa-f sh at once	Director	10e. Street and Nu						10f. Zip				. 10	g. Citizo	en of What Co		
	eath with the Maryland items 23a or 28a-f show ust be notified at once.		1230 K	ENDRIC	K ROAD						1237				U.S.		dian Black
	h with ems 23	Funeral	11. Marital Status	ed 2 Mar	12. Was Dec	orces?		. 13. Wa	s Deceder es, specify	nt of Hisp Cuban,	anic Origir Mexican, F	n? ( Spe Puerto R	cify Yes or No- ican, etc.)		White, etc.		Jian, Black,
	er deat , or ite		3 Widowed		1 Yes	2 <b>X</b>	No	1 🗆	Yes 2	No.	specify:				Specify:	CIHW	CE
	iurs aft itural" amine	d b			or Dates: fy only highest gra		ed)	16a. Deceder	nt's Usual (	occupation	on (Give ki	nd of wo	ork done d)	16b. K	ind of Busines	s/Industr	У
	6 172 ho an "ns ical Ex	ete	Elementary/Second 1 2	ondary (0-12)	College (	1-4 or 5+)			ISTRU						MARI	NE	
	5-0036 iled within 7 Hygiene. I other than the Medica	Completed	17, Father's Name	(First, Middle, L	ast)							Name (	First, Middle, M	Maiden S	Sumame)	_	
	215- be filed ntal Hy rked of	8	CHARL	ES	Ε.	WOL	FE				KATH	IRYN	10 10 11	-bas Cii	(SHE	ELY)	Code)
	21; hould bend Mer is mar	ဥ	19a. Informant's Na BRYAN W						g Address 7 GRI						ty or Town, Sta		21015
	Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a, Method of Dis	position				lace of Dispo	sition (Nan				Date	20c. l	ocation - City	or Town	, State
	Baltimore, permit. Pages I ar Department of Her Important: If ite		1 Burial 2	Cremation	3 Removal f			rematory or o CRO <u>CI</u>	י איז אים	rory		2-4	-2010	c	ATONS	VILI	LE. MD
	altin mit. Pa partmen portan rry or		4 Donation 5	Other Sperice t	tsensee		1415.3	22.	Name and	Address	of Facility	CVP	ACH/RO	SED	ALE F	UNE	RAL HOME
	Pe Pe III				Lasting that	eausad the	death	Do not enter	211 (	OHES	ACO	AVE ardiac or			ALE,	Ap	21237 proximate Interval
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of Chronic Alcohol Abuse												Be	etween Onset and Death	
	Examiner		Immediate Cause or condition result	(Final disease ing in death)	Due to (or as												
		_	Sequentially list c		b Due to (or as	a consequ	ence of	):								+-	
		mine	if any, leading to i cause. Enter Und (Disease or injury	lerlying Cause	C												
	led Insit	Exa	events resulting in	n death) Last	Due to (or as a consequence of):  d.												
	e executed cian and rial - transit	<u></u>	UNPENDE	D	AMENDED												
	Records, P.O. Box 68760,  The law requires that the death certificate be executed  are has been signed by the attending physician and  state has been signed for use as the burial - transi	/Mec	IF FEMALE: 23b. Was deceder	nt pregnant in th		, outcome	of pregr		etal death	3	Ectopic	pregna	ncy	23	<li>d. Date of deli Month</li>	very Day	Year
	of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate better this certificate has been signed by the attending physis rimeral director, case 2 should be detached for use as the but	sician/Me	past 12 month	ns?	4 Pre	gnant at tim	e of de		Other (Spe	cify)							
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	P.O.	J. P.		nincant conditi	ions contributing	to death b	G. 1. G. 1.						1 🗌 Ye	es 2	No 3 1	Probably	4 V Unknown
	ds, equire een sig ould bo	ompleted											24a. Was		prior	to comp	y findings available letion of cause of
	Recor The law ricate has b	gm											perf 1 <b>✓</b> Yes	ormed?	deat	h? Yes	2 No
		Ö	25 Was case ref	erred to medica							of Death			ا ا	ence 6 🗸 C	Other: So	ane
	Vita hysici rthis co	P B	1 🗸 Yes	2 No	Hospital: 1	Inpatient te of Injury		ER/Outpatie	لبيا ٠	DOA 28c, Inju	ry at Worl		g Home 5		jury occurred	otilei. So	
	n of \ding Ph; h. After the funeral	on	27 Manner of De 1 ✓ Natural	5 Pen	(Mo	nth, Day,Yea	r)	200. 11110	,,		Yes 2	,					
	ision Attend er death.	ficati	2 Accident	Inve	stigation 28e. Pl	ace of Injur	ry - At h	ome, farm, st	reet, factor	y, office l	ouilding, e	tc.			and Number o	or Rural F	Route Number, City
25. Was case referred to medical examiner?  1											etated						
Second Process of Parameters   Pending Investigation   Pending Investigation												to the ca	iuse(s)				
			11	1. 1.	and II.	M				O.C	M.E.			Fe	bruary 2, 2	2010	
	ī 7		30. Name and a	ddress of person	who completed o	ause of dea	ath (Iter	n 23a)	Don- O	troot !	Raltimo	re MID	21201				
	(2 V			rassell, MD	Assistant N	Medical E	xami	iner 11	Penns	nieet, l	Jailli 110	IC, IVID	21201				
		Stat	e 31. Date filed (A	B.A. SA	IU Leve	Sugar s	Alla	face									

To the Hospital or Attending filled in by the within 24 hours a

To the Funeral I

State

Registrar

29a. Certifier

29b. Signature and title of certifier

Medical

HAYASHI SSOS HOPKINS BAYVIEW CIRCLE, BALTIMORE MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D62032

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 1 2010 Physician/ 3:15 p <sup>M</sup> Zeinog, Jr. Richard F. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arundel Anne Severna Park 522 Lakeview Circle 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days Hours June 20 , °1925 84 Maryland Director 710-09-7736 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 United States 522 Lakeview Circle and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 **X** Yes 2 □ No **1942**-1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Executive Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Richard F. Zeinog Ella D. Blum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trac 1463 Ridgeway Avenue, Arnold, Maryland 21012 Jonathan D. Zeinog/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 February 2, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 2010 22. Name and Address of Facilit Cremation Society of Maryland, Inc. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. hronic 1645 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No X Natural 5 Pending a Hospius. 24 hours after death.

The Funeral Director: After the first on the first one first o Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one)

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifie

31. Date filed (Mor

12160

Margaret Carrico

, Day

FEB 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29c. License number

000473

808 Landmark Dr #128, Glen Burnie Maryland 21061

		For State Registrar  1. Decedent's Name		ems State C	f 'per'i	ie , g 900 <i>Ce</i>	rtificate	4 <b>72</b> 0 e of l	<b>Yodh</b> Death	Б 10 10	2. Date of De	eath		1 U	0 3 0 3 6
Physicia /Medic		George	Zavad								Januai				14:45 PM
Examin		4a. Facility Name (In		give street and nu edical Ce			Tows	son	Location	of Death		4	c. County o	imor	
Funeral Director		5. Social Security N 116-03-3		6. Sex 1 → M 2 □ F	7. Age (In yrs	. last birthday, 90 Yrs.	If Under Months	1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bi	r)	9. Birthplace (State or Foreign New York		
yland how at	Funeral Director	Usual Residence of 10a. State MD	Decedent 10b. County Baltin	ore		ity, Town or L	ocation							-	10d. Inside City Limits 1
with the Ma a or 28a-f s t be notified		10e. Street and Nur	mber				10f. Zip	Code 2120	4			10g. Citizen of What Country			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funera	11. Marital Status 1 □ Never Marr 3 □ Widowed	ied 2 <mark>⊠</mark> Marri	12. Was Dec	2 □ No ive \.\.\.T		Was Deced If Yes, spec		ilspanic O an, Mexica Specify		ecify Yes or N Rican, etc.)	14. Race - American Ir Black, White, etc.			etc.
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Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	(Final	complications that only one cause on a. Due to	caused the dea each line.	Jun	Sho	le of dyir	ng, such a	ns cardiac	or respiratory	arrest,	9		Approximate Interval Between Onset and Death
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ilng Ph After th uneral	on: T	27. Manner of Dea 1 Natural	5 Pendin	a Forth?	e of Injury th, Day Year)	28b. Time <b>Found</b>		28c. Inju Wo	ryat rk?  Yes 2 <b>X</b>	ZI Na	28d. Describe		_		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide	investig 6	not be ined 28e. Place built	o/10 ce of injury - At ding, etc. <i>(Spe</i> <b>lome</b>	2:15 1 home, farm, s	)		1160 2	_	Subject  28f. Location City or To  Ave., To	(Street own, St	and Number ate) 503	er or Ru	ral Route Number, Chesapeake
e Hospita 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one)	1 ☐ Certifyir 2 ☐ Medical	ng Physician: To the Examiner: On the	ne best of my k	nowledge, dea nation and/or	ath occurred	at the ti	ime, date opinion, d	and place	, and due to th	e cause	(s) and ma	anner as	stated.
To th within To th comp	Me	29b. Signature and	d title of certifie	He WI	10	~	29	c. Licens	se numbe		,	29d. I	Date signed	d (Month	, Day, Year)
		30. Name and add	lress of person	who dompleted car	use of death (It	em 23a) (Typ	e, Print)	XI	24	16/	· /	-19	inua	Mi	25,2010
		12h:1	17 P	1.1:1011	C M Regis rar's Sig	D6-		ble	Hil	10	Lithe	avil	le M	<u>G</u> ,	21093
Sta Regist		31. Date filed (Mo			negistial s old	. pa	May						•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 10g per inf g900 2-18-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Feb. Ann Spatz Zinser 2010 04 7:52 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore County Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Date of bill. (Month, Day, Year) 1 06,1934 7. Age (In vrs. last birthday **Funeral** Days Min. 1 □ M 2 🛛 F Director 212-52-3050 75 April London England Usual Residence of Decedent ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? England Funeral 1013 Marleigh Circle 21204 United States ural", or items? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 【XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene.
of Health and Mental Hygiene.
If item 27 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 04 Nurse Nursina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Heseltine Glady Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George Edward Zinser (Hus.) 1013 Marleigh Circle 21204 Towson, Maryland Baltimore, Date 05, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Page 1 cemetery, crematory or other place) Feb. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evans Funeral Chapel 2010 Forest Hill, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 Jeffrey L. Gair, Sr. an 12 Timonium, Maryland 23a. Feet 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sarcoma Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🕅 No Other: မြ Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R149194 February 4,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 N. Charles St Grant MD 21204 Towson, 31. Date filed (Month, Day, Year) **FEB 0 4 2010** 32. Registrar's Signature State Registrar

Regina Andree Arnold State of Maryland / Department of Health and Mental Hygiene 2010 03038 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day January 27, 2010 0039 hrs Medical Examiner ANDREE ARNOLD REGINA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center BelAir 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours Director 12-44-5419 1947 1 M 2 X F 62 Yrs West VA Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location in y 1 Yes 2 X No Harford Jarrettsville Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 United States 2050 Cox Road 23a Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 X Married 2 X No Yes White 3 Widowed 4 Divorced If Yes, Give Yee 1 Yes 2 No specify: Specify. than "natural". 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Housewife Home 12 0 tealth and Mental Hygiene. Item 27 is marked other the traumatic event, the Medi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goble Bruce Roark Nelle Inez Raymond 19a. Informant's Name/Relationship (Type, Print ) ( Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 084 Box Jarrettsville, Maryland William M. Arnold P.O. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, Feb. 1, crematory or other place) Burial 2 Cremation 3 Removal from State partment o arrettsville Cem Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licens E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Martica Death a. Atherosclerotic Cardiovascular Disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner eause. Enter Undarlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical  $^{ exttt{X}}$  AMENDED #31perDVR,G900,2/4/2010,WS UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown ned by the a signed by t I be detache contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? Yes 2 ✓ No death? certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this 2 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work' Certification: 1 V Natural Pending 1 Yes 2 No death. 2 Accident Investigation within 24 hours after d To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 \_\_\_ Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 27, 2010 el 30. Name and address of person who completed cause of death (Item 23a) **(**/5 Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Model) 32. Registrar's State FEB 0 4 2010 Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 7:15 PM F Abernathy 10 Joanne /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 11400 Valley Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Y Jan 13, 5. Social Security Number 7. Age (In yrs. last birthday) Days Min 1932 MD 214-28-7040 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cumberland MD Allegany 1 ☐Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 11400 Valley Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 | Yes 2 | If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 □ Yes 2 □ Xo Specify Specify. ģ white 3 □XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Ellsworth Effie Cooper Ellsworth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 7 Flintstone MD 21530 19a. Informant's Name/Relationship (Type. Print) Andrew Abernathy son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State S.S. Peter & Paul Cemetery 1/20/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 whiter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final 0 460 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or se a conescuence of) Examiner if any, feating to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 MNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1∐ Yes 2∭ Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident

The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, P.0. the signed by t Division of Vital Records, ficate has been sign, page 2 should b certificate has To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica funeral

**Funeral** 

Director

28a-f show

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items 23a

ò

'natural"

12 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n.

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau

**Physician** 

/Medical

**Examiner** 

traumatic event, the McCloal Evan instrument be notified at

72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

filled in by the

5 nds State Registrar

Medical

6 ☐ Could not be determined 4 Homicide

Day, Yea. N 25

3 Suicide

(Check only

31. Date filed (Month)

29b. Signature and title of certifier

29a. Certifier

5 Pending investigation

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

10

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

/ MID 2010

\*

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 **Physician** Jan 20 5:30p<sup>M</sup> Donald Lee Best /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner E1kton Ceci1 Union Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 17, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 233-68-8351 65 Nov. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhal must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ▼No Funeral Director Ceci1 MD North East 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21901 USA 7 Ginty Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. n MYes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Systems Engineer Financial Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Velma M. Cooper ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1092 Singerly Rd. Elkton, MD 21921 Angela Kay Best/ wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service 22. Name and Address of Facility Gee Funeral Home 259 E. Main St. Elkton, MD 21921 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** liones disease or condition resulting in death) /Medical Due to (or as a consequence f): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit Physiclan: The law requires that the death certificate be executed () resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical ass IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No o 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate 1 ☐ Yes 2XNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1X Natural 5 Pending investigation 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1-20-201C 30. Name and address of person who comple ted cause of death (Item 23a) (Type, Print) 201VA IQZ 31. Date filed (Month, Day, Year) State JAN 22 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 500 AM January apir Grace Anderson Medical Bantum Facility Name (if not institution, give, street and number) 4b. City, Town, or Location of Death Examiner 4c. County Hospital Easton1 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗗 F Months Days Hours 05-17-1928 Country) Director 81 214-26-3982 ۷a . Usual Residence of Decedent 10a. State 10b. County notified at 10c City Town or Location 10d. Inside City Limits Director 28a-f 1- Yes 2 No Md. Talbot Easton 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 22 South Aurora Street 21601 items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black. White, etc. ō 1 Never Married 2 Married þ and 2 should be filed within 72 hours after Health and Mental Hygiene. Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3. Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Moton High School Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Anderson Curtiss Grace Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Aurora Street, Easton, Md. 21601 <u>Curtiss J. Bantum/Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Richards Mem. Donation 5 Other (Specify) Easton, Maryland 21 - 10Agnature of Mineral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as consequence of) disease or condition resulting in death) - Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \) \( \bar{\lambda} \) No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an After this certificate has page 2 performe Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မ 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5  $\square$  Pending work? 24 hours after death. Funeral Director; A 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 17 Januar. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShields 219 S. Washington St. Eston, Md 21601 M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 2 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

			1 - For State Registrar	State of Ma	ıryland /		artmen <i>tificate</i>			and Me		giene Reg. N&	711111	03	042
	Physici		Decedent's Name (First, Middle, L     ANNIE	.ast) MARIE		BR	OWN				2. Date of De Month JANUAR	Day	y, 2010	3. Time 8:45	of Death
	/Medi Examir		4a. Facility Name (If not institution, g			DIC		Town, or	Location o		MINOAI		County of Dea		1
100			PRINCE GEORGE HO  5. Social Security Number 6.		(In yrs. last b	inth day)	CHEV:		If Under 2	24 Hre   7	Data of Div	- 1	INCE GE		
	Funeral Director		578-20-5347	1□M 2ĂF	86	Yrs.	Months	Days	Hours	Min.	3. Date of Bir (Month, Da L0-27-	1923	VIR	thplace <i>(State</i> o <i>untry)</i> GINIA	e or ⊢oreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation							10d. Inside	City Limits
	e Mary Ba-f sh	Director	MD PRINCE (	GEORGE	HYATT	SVIL	LE							1 ZYe	s 2□No
	with th	Dire	10e. Street and Number 1815 ALLENDALE	DIACE			10f. Zip					_	tizen of What C	ountry?	
	ems 23	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V			spanic Orig	gin? (Spec	ify Yes or No can, etc.)		14. Race - Am		
36	be filed within 72 hours after death with the Maryland that Hygiene.  Ad other than "natural", or items 23a or 28a-f show event, it is involved Evaminat must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced		0		□Yes 2		Specify:	, ruello Hi	can, etc.)		Black, Whit	e, etc. LACK	
2-C	72 hou natura	eted	15. Decedent's a	 Education	16	a. Deced	lent's Usua	I Occupa	ation	of working		16b. Ki	ind of Business		
21215-0036	2 should be filed within 72 and Mental Hygiene. Is marked other than "nat aumatic event, its in alledic	Completed	Elementary/Secondary (0-12) 9th	College (1-4or 5+		life. E	kind of worl OO NOT use FSS	e retired)	)	or working		PR	IVATE		
ğ	e filed tal Hyg d other event, I	BeC	17. Father's Name (First, Middle, Las			1111			18. Mother	r's Name (	First, Middle,				
Maryland	hould t id Men marked matic e	ဥ	SAMUEL EARL BUNDS  19a. Informant's Name/Relationship		140	6 M-00-			WILLI		NN LEW				
, Ma	and 2 sealth an 27 Is i		ROSIE HENRY/DAUGI		5	704	JOAN	LANE	TEMP	LE H	ILLS,	er, City o	or Town, State, 0748	Zip Code)	
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menti Important: If item 27 is marked any injury or other traumatic en once.	l W	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3			ery, cřem	natory or oth	her place	· 1	Dat			ocation - City or		
aitin	mit. Pa partme <b>sortani</b> / injury	ŀ	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lick	••	HARMOI					-26-2 JE JI			DOVER, ERAL HO		
ă	Depar Impo any ir	1 10	K.B. H-	rall									20785	0.11011	
	Physician	i e	23a. Part1. Enter the disease, br cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused t y one cause on each line ACUTE (	9.						respiratory a	rrest,		Approxima Interval B Onset and	etween
	/Medical		disease or condition resulting in death)	aDue to (or as a			OIINA.	ם טם	LLDIN						
	Examiner	e	Sequentially list conditions,	ACUTE 1 Due to (or as a			Y FAI	LURE					-		
	ransit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting indextby), set	cCARDIA	•		IΑ								
9/00,	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as a BREAST	consequence	of):					-				
00	rtificate ng phys as the	fedical	In the second of	_ d		***									
ם מ	attendir for use	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal deat		Ectopic pre					2	23d. Date of de Month	livery Day	Year
j	t the deby the by the tached	]	1 □ Yes 2 🖾 No 9 □ Unknown	4 □ Pregnant at t 9 □ Unknown	ime of death	5 🗆	Other (spe	ecity)						,	
, ,	res tha signed be det	by P	Part II. Other significant conditions	contributing to death but	not resulting	in the un	derlying ca	use give	n in Part I.				v		
cords,	w requi	leted								- :		es 2[		robably 4 🗆	
ב ב	Ine la ate has page 2	Completed									24a. Was autop perfor 1 □Yes		prior to death?	utopsy finding: completion of 2  No	cause of
\ .	certific	Be	25. Was case referred to medical examiner?	Hospital:				044-		of Death (	Check only o		T Lifes	2 110	
5	ig rnys terthis neral di	n: To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	28b.	Time of	3 □ DOA	Other Ic. Injury Work?	4 LI Nur		5 Resid		3 ☐Other (Spe y occurred	cify)	
	tendin leath. tor: Af the fur	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	20	-	Injury	М	1 □ Y	es 2□N	lo					
	al or Al s after o	Certification: T	4 Homicide determined		y - At home, fa (Specify)	arm, stre	et, factory,	office		28f	Location (S City or Tow		d Number or Ru )	ural Route Nu	m <i>ber,</i>
1000	or in respital or Attending Praystolan; The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier  (Check only one)  1 ☐ Certifying P  2 ☐ Medical Exa	hysician: To the best of miner: On the basis of e and manner state	examination a	e, death nd/or inv	occurred a estigation, i	it the time	e, date and inion, death	d place, and h occurred	d due to the at the time,	cause(s) date and	and manner as I place, and due	s stated. e to the cause	(s)
)	Nith Voir	Σ	29b. Signature and title of certifier	Karajai	Z- M.	)		License		859	5	29d. Date	e signed (Mont	h, Day, Year) 2010	
2	10		30. Name and address of person who CHANDRASEKHAR KO	•				TVF	CHEVE	TRT.V	MD 20	785			
Ì	Stat		31. Date filed (Month, Day, Year)	32. Registrar'	s Signature		TI DI		OILL VI	11111	110 20	, 05			
NII.	Registra		JAN 2 5 2010	ener B.	park										

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/Medical		resulting in death)	a.	Due to (or as a consequence		.,	- Ciclina	~ \	,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The law requires that the remaining physician and to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. c.	Due to (or as a consequence to (or as a consequence)	uence of):		FFICIEN				
P.O. Box 68760, at the death certificate be extra by the attending physician etached for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	230	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 🗆 Ecto					1	ate of deliver
S, P	y P	Part II. Other significant conditions		ibuting to death but not resi	ulting in the underly	ing caus	e given in Part I.		23e. Did tobac	co use cont	tribute to the
rd; quire an sig	D T	DIABETE	>						1 ☐ Yes	2 □ No	3 ☐ Proba
Reco	omplete	RHOUM A TOI	D	ARTHRIT	15				24a. Was an autopsy performed	1?	Were autop prior to con death? 1 \( \subseteq Yes
tal		25. Was case referred to medical	T				26 Place of De	ath //	1 □ Yes 2 <b>X</b> Check only one)	No	I L Yes
Vi sicia siceri	Be c	examiner?	Ho	spital: 1 ☐ Inpatient 2 🕞	P/Outpationt 3		Othor		5 ☐ Residence	o 6 🗆 O#	hor (Cappife
Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Certification: To	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	be	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At he building, etc. (Specif	28b. Time of Injury	28c.	Injury at Work? 1 □ Yes 2 □ No	286	d. Describe how	injury occur	red
Div	erti	4 ☐ Homicide determined	u	building, etc. (Specif	y)				City or Town, S	itate)	
e Hospite n 24 hours e Funera	Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	Physicamine	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occ tion and/or investion	urred at gation, in	the time, date and place my opinion, death occ	ce, an	d due to the cau at the time, date	se(s) and m and place,	nanner as st and due to
To th withir To th	Me	29b. Signature and title of continer					icense number ) 40324				ed (Month, I
cr 2		30. Name and address of person who TERMY JODRIE, W	ND,	FACEP 76	00 CARR	OLL	AVENUE,	TA	rema	PARK	MAR
Sta Registr		31. Date filed (Month, Day, Year) JAN 2 2 2010	Sen	32. Registrar's Sign	ale						
DHMH 17 Rev 1/20	001				ORIGINA	AL.				_	

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:42 P M January 16, 2010 Pauline Boyd /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 😾 F Yrs. 78 7/2/1931 Director 578-44-3506 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 3 any injury or other traumatic event. 10d. Inside City Limits 10c, City, Town or Location 10a State 10h County 1X Yes 2 □ No Director MD Prince Georges Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 US 6200 Riggs Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: Black ð 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie Jones 2 Levi Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10th St., NE Washington, DC 5008 Deborah Thomas / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln 1/25/2010 Brentwood, MD. 4 ☐ Donation 5 ☐ Other (Spegify) 21. Signature of Funeral Se 22. Name and Address of Facility Fort Lincoln Funeral Home censee 3401 Bladensburg Rd. Brentwood, MD. 20722 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the disea shock, or heart failu List only one cause on each line Immediate Cause (Final GASTRA INTESTIMA BLEF DING Year cause of death? bly 4🔀 Unknown sy findings available 2 □ No Route Number hate the cause(s) ay, Year) 1,2010 YLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month lara 876 2010 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Jachington Tekuma 101 hontronery 05 Social Security Number 7. Age in yrs. last birthday) 82 yrs. 8. Date of Birth (Month, Day, Year) JAN 29 1927 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 579-36-7026 1 🗆 M 2 🟋 F WASHINGTON, DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12406 LYTTON AVENUE 20613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No 1 ☐ Yes 2 X No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MATTIE FRENCH JESSIE BILLINGSLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS -DGT 12406 LYTTON AVENUE BRANDYWINE, MARYLAND DONNA L. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 E Burial 2 Cremation 3 Removal from State 1/23/2010 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY LANDOVER, MARYLAND 21. Sign wre of Fun Service Lensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME .01 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes orar prector; Atter this certificate has been si filled in by the funeral director, page 2 should in 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 DInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) LOID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01. 205 Crate

State Registrar Day, Year) 2 201

2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Physician/ Month Oralee Loraine Clouser 6.42 pm Unnam 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 і KF Days Hours Min Months 215-26-8576 Mary Tand Director 80 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Smithsburg 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11916 Seminole Dr. 21783 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 9 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Service Representative Bank & Trust Co. permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roland Smith Grace Elizabeth Violet Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Worden-daughter 505 Sullivan Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Smithsburg Cemetery | 1-25-2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Emply Demo Physician/ Severe disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir and I-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ lysidemia 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No hours after death.

neral Director: After this certific
d filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0H-6

Baltimore, Maryland 21215-0036

Box 68760

Records,

**Division of Vital** 

State Registrar Shahid

31. Date filed (Month, Day, Year)

580 Northern Au

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahmood

JAN 25

MD

32. Registrar's Signature

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		For State Registrar	State of Mary	rland / Depa	artment	of Health and of Death	Mental Hy	•	03046
Physic		1. Decedent's Name (First, Middle, Last,					2. Date of De. Month	Day Year	3. Time of Death 11:56 a M
/Medi Examii		Agnes Jeannette ( 4a. Facility Name (If not institution, give  Coffman Nursing	street and number) Home		На	own, or Location of Dear	,	25 2010 4c. County of Death Washingt	ton
Funeral Director		5. Social Security Number 6. Sec 213-18-9395  Usual Residence of Decedent	M 2NF	93 Yrs. last birthday)	If Under 1 Months	Year If Under 24 Hrs Days Hours Min.	. (Month, Da		place (State or Foreign intry) yland
death with the Maryland ime 23a or 28a-f show f mare be notified at	Director	10a. State 10b. County  Maryland Washingt  10e. Street and Number		c. City, Town or Lo	stown 10f. Zip C	<sup>2</sup> ode		10g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 No
th with	ai Dir	1304 Pennsylvania	Avenue			742		USA	into y :
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Macifial Examinatory and the notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decede f Yes, specif 1 Yes 2	nt of Hispanic Origin? (S y Cuban, Mexican, Puer X No Specity:	Specify Yes or No to Rican, etc.)	Specify:	
within 72 hound.	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	(Give	DO NOT use	done during most of wo	erking	16b. Kind of Business/I	ndustry
Id be filed vental Hygie	To Be Co	12 17. Father's Name (First, Middle, Last)  Joseph Elmer Down	0	C1e	rk	18. Mother's Na	,	Retail Maiden Sumame)	
2 shou and M is mar	-	19a. Informant's Name/Relationship (Ty		19b. Mailii	ng Address (			er, City or Town, State, Z	ip Code)
s 1 and f Health item 27 other to		Patsy Miles - Dau 20a. Method of Disposition		20b. Place of Dispo	natoni or oth	of par place)	Date	Md . 21795 20c. Location - City or 1	Fown, State
permit. Pages Department of Mportant: If it any injury or once		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Cedar La	wn Mem	orialPark	3/10	Hagerstown	Md.
Departing Departing Important		21. Signature of Funeral Service Licens	estel		. Name and	Address of Facility 1	linnich l	Funeral Homestown, MD 21	
Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	The second secon	death. Do not ent		of dying, such as cardia			Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	BMEN	MA			MONTHS
to the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnani in the past 12 months? 1 □ Yes 2 ™No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pred Other (spec			23d. Date of deli-	very Day Year
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ysician is certifi director	o Be	25. Was case referred to medicat examiner?  1 ☐ Yes 2 ☑ No	lospital:	2 ☐ ER/Outpatier	at 3□ DOA	1	ath Check only o	one] dence 6 □Other (Spec	ufv)
To the Hospital or Attending Physical Compilers of the Funeral Director. After this completely filled in by the funeral director.	ation: T	27. Manner of Death  Natural  Accident  To Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time o		c. Injury at Work?		how injury occurred	
pltal or Att urs after di aral Direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Specify)			City or Tox		
Ne Hosp 124 hous Ne Fune	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or in	occurred at vestigation, in	t the time, date and place in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the Comp	Me	29b. Signature and title of certifier	) 0.4		29c.	License number		29d. Date signed (Month	
4		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type,	Print)	D46561		JAN, 25	, 2010
3H-1		GHAZMA QM	11 1190	mr A	ENA	ROM H	MENIN	OM GE	1740.
Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Las				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 03047 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 3:52 рм 23 2010 Jan. Edwin Lee CRIDER, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport nder 1 Year | If Under 24 Hrs. Homewood at Williamsport Washington Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**∑** M 2□ F Yrs. 97 Director Oct. 12 1912 Maryland <del>173-03-1724</del> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Maryland | Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 1508 Howell Road 21740 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 - 60 Delivery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Crider ဂ္ဂ Virgie Barnhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara S. Harrell - daughter 17855 Carter Lane, Hagerstown, Md. 21740 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Rose Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home fred 415 E. Wilson Blvd. Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vanca ho do disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Fibri Met Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Kalins Schuckie Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, openda 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Kidu performed 2 10 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 4No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After that in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🖪 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JA~ 24,2040 -au WD 12 (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HACCRSTOWN MO 21740 JH 3 MILLIT VASAVT NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 26 2010 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Forrest Dale Chapman January 22, 2010 04:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 19710 Shaft Road, S.W Allegany Midlothian 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** NOM 2□F Months Days Hours Min Director 216-22-7273 84 October 29, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19710 Shaft Road, S.W. 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify \$ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) engineer tire manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Lester Chapman ဂ္ Bessie Willetts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Chapman 19710 Shaft Road, S.W. Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park January 24, 2010 Frostburg 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mounts disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 mostys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 【】 No 3 ☐ Probably 4 ☐ Unknown Completed 240 1//00 00 24h Wara autonou findi page 2 funeral director, Be Certification: To

Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, has certificate Hospital or Attending after death Director: / d in by the fi 24 hours a

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

show

marked other

Pages 1

/ \\\					autopsy performed?	prior to completion of cause of death?  1 □ Yes 2 □ No	
25. Was case referr examiner?	ed to medical			26. Place of Dea	ath (Check only one)		•
1 Yes 2 🗹	Vo	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 ☐ [	lome 5 Presidence 6	Other (Specify)	•	
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	l Number or Rural Route Number,	
29a. Certifier (Check only	1 ☐ Certifying Ph 2 ☐ Medical Exar	nysician: To the best of my kno niner: On the basis of examina	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)	•

29c. License number

completely within 2 bt

filled in I

Name and address of person who completed cause of death (Item 23a) (Type, Print) 2500

Doger

29d. Date signed (Month, Day, Year)

22 2010

State Registrar

Medical

29b. Signature and title of certifie

Chaplain, Mildred

			Please	e Type or Pri					•	ble.
			For State Registrar	State of M	aryland / Depa <i>Cer</i>	artment of F <i>tificate of D</i>		, ,	giene Reg. No. 20	10 03049
	Physicia	n/	1. Decedent's Name (First, Middle, La					2. Date of Deat	th	3. Time of Death
-	Medic	al	MILDRED IRENE					Januar	R	Year Olo Oq30 AM
	Examin	er	4a. Facility Name (if not institution, given the Memorial Hospi	ŕ	ton	4b. City, Town, or Easton	Location of Death		4c. County o	
	Funeral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1	Birthplace (State or Foreign Country)
	Director		218-34-9128 Usual Residence of Decedent	1	96 Yrs.			11/13/	1913	MARYLAND
	yland f shov ed at	tor	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits
	ne Mar or 28a- notifi	Director	MD CAROI  10e. Street and Number	LINE	PRESTO	N 10f. Zip Code			400''	1 🗆 Yes 2 🚺 No
	with the	Funeral	5730 NEWTON ROA	AD		216	555		10g. Citizen of W	nat Country?
	death r items ner m	Fun,	11. Marital Status	12. Was Decedent E Armed Forces?		Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc.
036	s after ral", o Exami	ed by	1 ☐ Never Married 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No 1	☐ Yes 2 🗶 No	Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest g	Education		lent's Usual Occupa kind of work done d		ina	16b. Kind of Bus	siness Industry
121	ithin 7 iene. r than	Con	Elementary/Seconday (0-12)	College (1-4 or 5	+) life. Do	O NOT use retired)  MEMAKER	J		OWN	nu <b>m</b> e
Q	ent oth		17. Father's Name (First, Middle, Last)		1 10		18. Mother's Nam	e (First, Middle, M		понь
Maryland	should be fil and Mental is marked aumatic ev	J.	JOHN WESLEY STU					ULLIKIN		
<b>∑</b>	12 shoalth and 27 is i		19a. Informant's Name/Relationship ( PATSY PLUGGE/DA)	•		g Address (Street a 5730 NEW)		,		ate, Zip Code) 1655
Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispos			Date		City or Town, State
ţi	it. Pag rtment rtant; njury c		4 Donation 5 Other (Spec	cify)	WOODLAWN	MEMORIAL	PARK 1/2	22/2010	EASTON,	MARYLAND
Ba	perm Depa Impo any i	85 A	21. Signature of Funeral Service Licer	nsee NERCER:	′ \   1	. Name and Addres	s of Facility <b>HELFENBE</b> ]	in & new	NAM FUNI	ERAL HOME, P.A.
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Box 68760	tificate ng phy as the	Physician/Medical	IF FEMALE:	_ u,						
9 xc	ath cer attendii for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth 4 Pregnant at	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)	<b>∀</b>		23d. Date Mont	of delivery th Day Year
Ö.	the degrapher of the sached of	hysi	1 Yes 2 No 9 Unknown	9 Unknown	time of death 5 L	Other (specify)				
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Ę.	<b>Physician:</b> The lav r this certificate has aral director, page 2	မ	1 Yes 2 No		ent 2 ER/Outpatien		4   Nursing Ho		ence 6 🗆 Other	
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	Vith vith Com at the com		29b. Signature and title of certifier			29c License	number	2	9d. Date signed (	Month, Day, Year)
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F	35		30. Name and address of person who	· 11 / Len	eath (Item 23a) (Type, Pi		19 SOUTH	WASHING	TON STRE	21601 EET, EASTON, MD
	Stat Registra	e ir	31. Date filed Month, Day Year 9	2010 32. Registra	r's Signature	are				

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

			For State	State	of Mary	land / Depa	artment o		and M			ZUIL	03	051
			Registrar  1. Decedent's Name (First, Mid	dle, Last)	_		imouto o	7 Doutin		2. Date of Dea	Reg. No	),	3. Time of	Death
	Physicia Medic		ESTIL CLAY							Jan.	21	5,2010	4:42	РМ
	Examin	er	4a. Facility Name (if not institut	-		0 m + m		n, or Location	of Death		4c	. County of Deat		
Sec. 1	Funeval		Upper Chesar  5. Social Security Number	6. Sex		yrs. last birthday)	Bel If Under 1 Ye	Alr ear   If Under	24 Hrs.	8. Date of Birt	h		ford thplace (State o	or Foreian
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	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examinar must be notified at the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Dec	edent Ever i	in U.S. 13. V	Vas Decedent o	of Hispanic Ori	gin? (Spe	cify Yes or No-	Т	14. Race - Ame		
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643 Maryland 21	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	입	William J.	Daniels				Jo	seph	ine Sn	nitl	h		
lar,	should be and Ment is marked raumatic e		19a. Informant's Name/Relation		_							Town, State, Zij		
> 6	and 2 lealth im 27 her tr		Trudy W. Da	aniels/Wi						<u>_</u>		reet, 1		54
<u>S</u>	ge 1 g nt of F : If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3 🗆 Removal from	m State		natory or other p	place)	_	ate		ocation - City or		
<b>₽</b>	it. Par urtmer urtant njury	4 Donation 5 Other (Specify) Emory Cemetery 1/29/2010 Street,  21. Signature of Emperal/Service Licenses 22. Name and Address of Facility										treet,	MD	
E B	permit. Departr Imports any inji		Carrent service	f follow	AM	I			•	Home,	Ind	c., De	lta, P	A1731
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053 Box 687	th cer trendi	ian/	23b. Was decedent pregnant in the past 12 months?		e Birth 2 🗌	Fetal death 3						23d. Date of de Month	-	Year
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∑ Sign	w req	plet	Severe b	one mai	MUN	Suppre	usiov	1		24a. Was a	SV	prior to	topsy findings a	available cause of
S	The law ate has page 2 s	Som				•				perfor	rmed?	death? o 1 ☐ Yes	2 No	
tal	cian: ertific sctor,	Be (	25. Was case referred to medic examiner?	al Hospital:				6. Place of Dea	th (Check					
≲ ≥	Physic this c al dire	ဥ	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 1 2		2 ER/Outpatier	t 3 LI DOA					Other (Spec	ify)	
	ding F h. After funer	ate	1 Natural 5 ☐ Per	ding (Mo	e of injury nth, Day, Yea		l v	njury at vork? □ Yes 2□	- 1	28d. Describe h	ow injur	y occurred		
sib	Attending Physician: The law requires that the sr death. setor: After this certificate has been signed by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach.	Certificate:	3 Suicide 6 Cou	stigation ald not be ermined 28e. Place	e of Injury -	At home, farm, stre						d Number or Ru	ral Route Numb	ber,
子言	spital or Attending Physician: The Is ours after death. eral Director: After this certificate ha filled in by the funeral director, page		4 - Hornicide dete	build	ding, etc. (Sp	pecify)				City or Tow	n, State	)		9
TS a	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 - Medica	ing Physician: To the al Examiner: On the ba	asis of examin	nation and/or invest	igation, in my or	pinion, death o	ccurred at	the time, date a	nd place	e, and due to the	cause(s) and ma	anner stated.
	To the within To the Somple	Σ	only one) 3 \(\subseteq\) Certify 29b. Signature and title of certify	ing Nurse Practioner	7	or my knowledge, o	29c. Lice	ense number				s) and manner as ite signed (Monti	h, Day, Year)	
			1 hlam	klul	/		0	6347	70		Jav	mary	25, 20	010
	, K		30. Name and address of person	on who completed cau	use of death		- 1	,	0 -	0 (	A - 1	0-0	0.1	1
	15		31. Date filed (Month, Day, Year	aral, m.f	Registrar's S	upper (	Mesax	seake	J)(,	Beld	tig	mo	7101	1
	Stat Registra		FEB 04 2		negistrars S	Bare	<b>"</b>							

		1 - For State Registrar	State of Mai			t of Heal			/	010	030	052
		Decedent's Name (First, Middle,)	Last)		77 47.1.0	, 0, =		2. Date of Dea			3. Time of	Death
Physic Med		William	Anthon	.y	DeHa	rt		Januar:	y 2 <sup>Day</sup> ,	2010	1727	P M
Exam		4a. Facility Name (if not institution, g	,			Town, or Locat				nty of Death		
Funera		14221 Oak Sprin  5. Social Security Number	<u> </u>	'In yrs. last birthday		erstown	n nder 24 Hrs.	8. Date of Birt		hington	n ice (State o	r Foreign
Directo		219-52-1743	117 M 2 D E	60 Yrs.	Months	Days Hou	urs Min.	(Month, Day June 1	v Year)	Country	()	
ow	_	Usual Residence of Decedent  10a. State 10b. County	Ι,	10- Oto Town or								
a-fsh fieda	Director			10c. City, Town or I						100	d. Inside Cit	ity Limits
perfin., rage I and 2 should be the within 2 hours after death with the maryland perfin. I rage I and 2 should be the will the maryland important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at mone.	Dir.	MD Washin  10e. Street and Number	igron	Hagers	10f. Zip	Code			10a. Citizen o	of What Country		∠ <b>№</b> 140
23a ust be	Funeral	14221 Oak Sprin	ngs Road		2	21742				.S.A.		
items rer m	필	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	. Was Deced	ent of Hispanic	c Origin? (Spec xican, Puerto P	cify Yes or No-		ace - American		
ull", or xamir	d by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 🗌 Yes 2 🗓 No If Yes, Give	5		2 X No <i>Sp</i> e			Specif	lack, White, etc		
natura ical E	Completed	15. Decedent	Year or Dates. t's Education	16a. Dec	edent's Usua	Occupation				White Business Indus	_	
e. nan "r Med	g E	(Specify only highest Elementary/Seconday (0-12)	t grade completed)  College (1-4 or 5+)	(Giv		k done during i	most of workin	ng		ronmen		11
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alth an 27 is r trau		Joanne S. DeHart						Route Number Hager:			<sup>de)</sup> 742	
of Heg fitem	4	20a. Method of Disposition	2 □ B 1 ( 2) (	20b. Place of Dis	position (Nam rematory or ot		D	Date	20c. Location	n - City or Towr	n, State	
ment ant: I		1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		Smithsbu			1/26	/2010	Smith	sburg,	MD	
er min	52	21. Signature of Funeral Service Lic	ensee			d Address of F		st Have			-	
10 = # C	21	23a. Part 1. Enter the disease, or c	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~					ve., Ha				
		shock, or heart failure. List on Immediate Cause (Final		ie death. Do not e	THE THOUGH	or dying, such	Tras cardiac or	respiratory arr	esi,	lr	Approximate nterval Bety Inset and D	ween
nysician Medica	_	disease or condition resulting in death)	a. Due to lar as a c	consequence of):	260	M (	Oc.	-	7	/	CO	
Examine		O annualistic teleproperties	Chho	me (	9108	FEU!	Ou	Q /C	ilen	Ses >	en	LS.
	ine	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a c	consequence of):		7	7	1200	~ (°)	0	Co 0	. 0
and -trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due in (or as a c	manufaction of the consequence o	Ł (J	12/02	47	715C	ax	4	con	4
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the the	Aedi		d	V		$\longrightarrow$						
attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2	pregnancy	□ Ectopic p	radnancy			23d. E	Date of delivery	,	
he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown		Other (spe				Ι.	Month Da	ay Y	Year
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signe d be o	d by	21	Blin	elee		2		1 12		3 🗌 Probak		
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rtificar stor, p	Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check		24 No	1  Yes 2	□ No	
his certific I director,	10 E	1 Yes 2 No	Hospital: 1  Inpatient	t 2 ER/Outpat		Other: 4 [	☐ Nursing Hor	me 5 🛚 Resid	lence 6 🗆 Ot	ther (Specify)		
). After t	ate:	27. Manner of Death 1 D Natural 5 □ Pending	28a. Date of injury (Month, Day, )	Year) 28b. Time injury	,	Bc. Injury at work?		28d. Describe h	ow injury occu	rred		
death ctor; / y the i	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	- At home form	M M	1  Yes		29f Leastion /S	Street and Mum	har ar Bural B	auta Numb	
after   Dire   d in b		4 ☐ Homicide determin	building, etc. (	Specify)	licei, iacioi,	Unice	ſ	28f. Location (S City or Tow		Der Or Hurarin	Jule Ivamo	er,
hours Ineral	Medical		Physician: To the best of my									
within 24 yours after death.  To the Funeral Director: After this completed filled in by the funeral directoral directory.	Mec	only on 3 Certifying N	taminer: On the basis of examiner: On the basis of examiners of the basis of examiners.	mination and/or invest of my knowledge	e, death occurr	red at the time,	, date and place	e, and due to the	e cause(s) and r	manner as state	ed.	
So o		29b. Signature and title of certifier	- 111		29c.	License numb	per (7)31		29d. Date sign	ned (Month, Day	y, Year)	
		le constant de la con	gw mil	·· (1) - 00a) (Time	2	0000			Jun	00 20	10.	
1-2		30. Name and address of person when SHATAB	10 completed cause of deal	th (Item 23a) (Type	MD :	324 E	3 am	wita	in 87	Foreel	HA	GMD)
St	ate	31. Date filed (Month, Day, Year)	32. Fegistrar's	s Signature				•				470

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da Month **Physician** 2010 January 20, 11:55 P<sup>M</sup> James Gershom Dawson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Retirement Village Williamsport Washington Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 94 30, 1915 Maryland Director 213-16-0292 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh t be notified 1X Yes 2 □ No Director MD Williamsport Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 21795 USA 154 Artizan St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No þ Specify: 3 XWidowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Furniture Touch Up</u> <u>Furniture</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margie Viola Sprankle John Gershom Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1020 Beechwood Dr. Hagerstown, MD 21742 Sandra K. McGowan / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/25/2010 Hagerstown, MD Rose Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Euneral Service Licenses any ir once. 37 <u>305 N. Potomac St. Hagerstown, MD 21740</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION Physician PNEUMONIA いでにと /Medical Due to (or as a consequence of) Examiner DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transit CEREBIRO VASCULAR Exami DISEASE and Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð RENM 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas certificate l 2 3 No 1 Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🔲 Inpatient မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After tl After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3370 ANWARY 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTIZAN WILLIAMS BOIZT, HOWE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 85

DHMH 17 Rev 1/2001

Registrar

**Physician** /Medical **Examiner** 

Baltimore, Maryland 21215-0036

the burial-tran Box 68760, P.0. Division of Vital Records, certificate this

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 20°, 2010 JANUARY ALVAJEANNE 0. **EDWARDS** 0005A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, MAY 15, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2 🔀 F Months Days Hours Min. 578-22-3929 ILLINOIS 86 1923 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location or 28a-f shov traumatic event, the Medical Evaniner must be notified at 1X Yes 2 □ No Directo MD PRINCE GEORGE BRANDYWINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13509 S. HILL RD 20613 U.S.A. 'natural", or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 □Yes 2 No þ Specify 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 12th College (1-4or 5+) GOVERNMENT permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other thar any injury or other traumatic event, the May injury or other traumatic event. **SECRETARY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARVIN FREEMAN HELEN FOSTER ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE WASHINGTON/DAUGHTER 13509 S. HILL RD BRANDYWINE, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nourial 2 Cremation 3 Removal from State HARMONY MEMORIAL 1-25-2010 LANDOVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KIDNEY FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 🕅 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 2 X No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 1-20-2010 D61887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRA RABIN, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's State JAN 2 **5 2010** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EDITH LOUISE FLETCHER Jan. 4:44 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Pennsylvania Months Days Hours Min 78 170-24-1842 **Director** Usual Residence of Decedent 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified 1 Tes 2X No Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2000 Jerrys Road 21154 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner r 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2X No Specify. 3 XWidowed 4 ☐ Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 77 is marked other traumatic event, the Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milton McSherry Pearl Phipts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr Gene L. Fletcher Street, Maryland 21154 Jerrys Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jan. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Paul Cemetery 2010 Pylesville, MD. Signature of Funeral Service Licenses 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage
Due to (or as a consequence of) Ph sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 i yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 XNo

9 Unknown Month Day Year Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2. No ٩ 1 Yes HOSPILO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \[ \text{Yes} 2 \[ \text{No} \] 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif who completed cause of death (Item 23a) (Type, Print) Valley

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Evelvn Feller 14, 201<sup>vea</sup> January 9:41 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours May 6 Min. 198-05-5406 92 PA Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f 1X Yes 2 No Prince Georges Greenbelt 10e. Street and Number 6 10f, Zip Code 10g. Citizen of What Country? Funeral ll Ridge Road, Unit M 20770 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H မ of Health and Menta fitem 27 is marked rother traumatic e Raphael Dickman May Nager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37101 South Golf Course Drive, Tucson, <u>Ronald R. Feller / son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🔀 Burial 2 🗌 Cremation 3X Removal from State King David Mem. Grdn. 01/17/2010 Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility National Funeral Home 7482 Lee Hwy. Falls Church, VA 22042 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Physician/ Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Acute Myocardial Infarction 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 XN Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 ☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Signature

Anurita Mendhiratta,

31. Date filed (Month, Day, Year)

D38262

2401 Research Blvd. suite 330, Rockville, MD 20850

January 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 03057 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 19-2010 JOSEPH N. FARRELL 05:17 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Davs Hours 7, Day, Year) 7–1954 (Month West <u>Indies</u> Director 55 022-64-0601 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Marvland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral West Indies 3407 Marlborough Court 20740 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Yes Give 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Michael Farrell Emma Greenaway 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosanna Brown/sister 6502 Hallam Court, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it is any injury or c 1 Burial 2 X Cremation 3 Removal from State Riverdale Crematory Riverdale, Maryland 1/25/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility May Hedgman MO1374 Cedar Hill FH, 4111 PA Ave.,Suitland, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner FAILURE NOFITIVE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): DIABETES Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): SERZUNE MEURDER Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month signed by the a Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 5ALCO100815 1 Yes 2 NO 3 Probably 4 Unknown Completed peen AYDERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy SCHIZOPHRENIA 1 Yes 2 No Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 110 Other: 1 Depatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State

Box 68760 P.O. filed within 72 hours after death

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be Division of Vital Records. this certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: All completed filled in by the fu

State

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAUTO SHAMIN MD., WASHTUGTON ADVENTIST HOSP, TAKOMOTPARK, MD-20912

01/19/2010

filed (Month, Day, Year, JAN 2 2 2010

32. Registrar's Signature

Registrar

Medical

Amended	l #23	a(	b), Part II, <b>Pleas</b> , 01/28/10,	e Type or P	Print in E	Black Ir	ndelible In	k. Ensu	ure All Co	pies A	re Legib	le.	
Allegan	- F	/	For State Registrar	State of	Maryland	d / Depa	artment of tificate of	Health a	and Mental	Hygie Reg.	ne 201		3058
PI	hysicia Medic		1. Decedent's Name (First, Middle, LeRoy	Edward		Gray			2. Date Mon	of Death th	Day Ye	3. Time	e of Death
	Examin		4a. Facility Name (If not institution, g					berland		Ĭ	4c. County of I	Death	
Di	uneral rector		5. Social Security Number 215-36-9595  Usual Residence of Decedent	Sex 1 □ M 2 □ F 7.	Age (In yrs. Ias	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date	of Birth th. Day OV 27	<sup>ar)</sup> 1939	. Birthplace (State Country)	te or Foreign
Aaryland	8a-f show tified at	rector	10a. State 10b. County	egany	10c. City,	Town or Loc	mberland	1					City Limits
with the A	s 23a or 2 ust be no	Funeral Director	10e. Street and Number 14109 Cedarw	ood Drive	`		10f. Zip Code	215	02	10g.	Citizen of Wha	it Country?	
and 21215-0036 be filled within 72 hours after death with the Maryland ental Hygiene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forcer 1	s? □ <b>X</b> No	lf	Vas Decedent of I	an, Mexican,	in? (Specify Yes of Puerto Rican, etc	r No- c.)		American Indian, White, etc.	
d 21215-0036 ed within 72 hours after Hygiene.	her than "nat t, the Medica	e Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 c	or 5+)	(Give k life. DC	ent's Usual Occu ind of work done O NOT use retired hinist	during most of	of working	165	P.V.R.	ess Industry  Compan	ıy
0 5 5		To Be	17. Father's Name (First, Middle, Las Melvin Edwa	•					's Name (First, M elda Lillia		,	Gray	
e, Maryl and 2 should I	əm 27 is marke her traumatic		19a. Informant's Name/Relationship Roy Gray		on		g Address (Street 53 Baltim	and Number Ore Av	or Rural Route N <b>enue</b>	umber, City Cuml	or Town, State Derland	MD 2	21502
Baltimore, Permit. Page 1 and Department of Hea	Important: If item 27 is any injury or other trau		20a. Method of Disposition  1 M Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	ate Su	nset Me	sition (Name of latory or other pla emorial Par			/2010	. Location - City	y or Town, State <b>erland</b>	MD
<b>Ba</b> perm Depa	lmpo any i		21. Signature of Funeral Service Lice					Virginia A	venue: Cur	nberlan	d, MD 215	02	
	edical		23a. Part 1. Inter the disease, or co short, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each l	line.	Rena	r the mode of dyir		ardiac or respirate	ory arrest,		Approxin Interval E Onset an	Between
Exa	miner	iner	Sequentially list conditions, if any cause. Enter Underlying	b. —	etes Me		s					Years	
be executed	E :0	al Examiner	cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last	c. Due to (or a	as a conseque	nce of):							
38760 rtificate b	e as the t	/Medic	IF FEMALE:	d									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 blours after death. The financial principle of the continued by the attended to the continued by the attended by the	oy the attend ached for us	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcom 1 ☐ Live Birtl 4 ☐ Pregnant 9 ☐ Unknow	h 2 🔲 Fetal of t at time of de	death 3 🗌	Ectopic pregnand Other (specify)	Су		_	23d. Date of Month	delivery Day	Year
ds, P.C	uld be deta	ted by P	Part II. Other significant conditions	contributing to death			derlying cause gi					e to the cause of	
Division of Vital Records, all or Attending Physician: The law requires is after death.	oage 2 sho	omple	my o contral	2-pri	Hent	Frile.	rd - ac	nt n	_	Was an autopsy performed? Yes 2.2	prior death	autopsy finding to completion of h? Yes 2 \sum No	s available f cause of
ital	ector, I	e l	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		-//	Oth		(Check only one)				
of V g Phys	eral di	e: 70	27. Manner of Death	1 Z impa 28a. Date of in		8b. Time of	3 DOA 28c. Injur	4 L Nurs	sing Home 5 2		6 Other (Su	pecify)	
tendin death.	the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	he		injury		? Yes 2□N	lo				-
Division Applies after after ours after or all Directions	filled in by		4 ☐ Homicide determine	building, e	etc. (Specify)		et, factory, office		City o	r Town, Sta	te)	Rural Route Nur	nber,
the Hos nin 24 hu	npleted	Med	only one) 3 Certifying Nu	ysician: To the best on niner: On the basis of rse Practioner: To the	t examination a	and/or investi	ration in my opinio	on death occi	irrad at the time of	late and pla	co and due to th	he causeo(s) and n	nanner stated.
	2 2		29b. Signature and title of certifier				29c. License	e number -1244	29d. Date signed (Month, Day, Year)  1/26/20/0				
no			30. Name and address of person who	completed cause of	death (Item 2	3a) (Type, Pri	Y STRE	ET F	FROSTR	URG	, MO	2153	Z
Re	State egistra	-	JAN 28 2010	32. Regist	trar's Signatur	arked	,						-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03059 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ JAMES LEO GALLAGHER 2 0 10 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Easton Memorial aston Tal tospita 501 Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 🛣 M 2 🗆 F Hours MARYLAND Director 213-14-1355 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No MD CAROLINE PRESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 MAPLE AVENUE 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. δ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Yes 2 No 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) h and Mental Hygien 7 is marked other tl EQUIPMENT COMPANY 12 SELF-EMPLOYED/OWNER Be other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ETHEL WOOD JOSEPH LEO GALLAGHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIOLET T.GALLAGHER/WIFE 109 MAPLE AVENUE, PRESTON, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) SPRING HILL CEMETERY 1/23/2010 EASTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Day Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No signed by the page 2 should be detached tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Kunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed? Yes 2.4 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending injury 1 Yes 2 No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of \$062676 who completed cause of death (Item 23a) (Type, Print) 30. Name and add

Registrar
DHMH 17 Rev 7/2009

State

4 SOWN.

istrar's Signature

19

State of Maryland / Department of Health and Mental Hygiene 03060 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ELOUISE GRIFFIN Medical ANUARY 2010 :36P 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 247-64-3953 72 1 □ M 2 🖳 F Months Days Hours MAY 28°, 1937 SOUTH CAROLINA Director Usual Residence of Decedent fshow "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No MD PRINCE GEORGE UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11305 PARKMONT DRIVE 20772 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Specify BLACK permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th ADMINISTRATIVE CLERK PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ANDREW GRIFFIN ELLA SINKLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALARIE T. JOHNSON/DAUGHTER 11305 PARKMONT DR UPPER MARLBORO, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY01-28-2010 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MD 21. Signature of Funeral Service Licenses 22, Name and Address of Facility JB JENKINS FULERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner amentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 1 ☐ Yes 21 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4🔎 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No in 24 hours after control of the funeral Director. After this communitied filled in by the funeral director, pr 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 8 26. Place of Death (Check only one) ဂ Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examine or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check On the basis of examination a a neglor investigation, in my opinion, death occurred at the time, date and place, and doe to the safety. Anowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one Certifying Nur Practioner: To the best 29b. Signature and 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ <sup>Day</sup>8 2010 JÄNUARY GRAYSON 8:20 A M ROSIE MAE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S MANOR CARE NURSING HOME LARGO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth Funeral 1 □ M 2 🖔 Months Days Hours Min MARCH<sup>ay</sup>1 T <sup>27</sup>1935 VIRGINIA Director 227-46-2618 74 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No PRINCE GEORGE'S CHEVERLY ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6012 REED STREET 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo BLACK 1 Yes 2 No Specify: "natural", 3 X Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY GOVERNMENT 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ HENRY L. GADDIES EDITH M. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH M. GRAYSON/DAUGHTER 6012 REED STREET CHEVERLY, MARYLAND Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Veterans Cemetery 1/25/2010 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 22. Name and Address of Facility 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ MALIGNANT CARDIAC ARRHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) -transit CONGESTIVE HEART FAILURE that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical ADVANCED DEMENTIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 🔀 No g Unknown q | I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗋 No 3 🗍 Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 😾 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital

Other:

28c. Injury at

M

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

work'

29c. License numbe D66658

1 Yes 2 No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/19/2010

20770

attending physician a for use as the burial-Box 68760 the is been signed by the should be detached P.O. Records, certificate has funeral director,

Baltimore, Maryland 21215-0036

Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: All completed filled in by the fu

REXFORD BABILAH M.D. 31. Date filed (Month, Day, Year) State Registrar

1 🗌 Yes

27. Manner of Death

1 🔀 Natural

Accident

Suicide

3 ☐ Sulcide 4 ☐ Homicide

29a. Certifier

၉

Certificate:

2 📆 No

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

Investigation

determined

6 Could not be

7500 HANOVER PARKWAY #101A GREENBELT, MARYLAND

28a. Date of injury (Month, Day, Year)

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

**Physicia** /Medica Examine

Funeral Director

•	For State Registrar	ate of Maryland		ficate of L			Reg. No	Z 11 1 11	03062		
an a	1. Decedent's Name (First, Middle, Last)					Date of De Month	eath Da	ay Year	3. Time of Death		
al	BARBARA ELLEN	HOPPERS						28 201			
er	4a. Facility Name (If not institution, give stree 211 Short Cut Ro				Location of Death			County of Deat	n		
	5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	Cecil 9. Birt	hplace (State or Foreign		
	175-28-0658	2X F 82	Yrs.	Months Days	Hours Min.	April	6 1		gland		
	10a. State 10b. County	10c. City	, Town or Locat	ion		_			10d. Inside City Limits		
ctor	MD Cecil	Ch	esapea	ke Cit	У				1 □ Yes 2 🔀 No		
Oire.	10e. Street and Number	, , ,		10f. Zip Code			_	itizen of What Co	untry?		
ral	211 Short Cut Rd	l.		2191	5		U	.S.A.			
nue	A	Vas Decedent Ever in U.S rmed Forces?	5. 13. Was	s Decedent of Hi es, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, White			
d by F	1 □ Never Married 2 □ Married 1  3 □ Widowed 4 □ Divorced Y	□Yes 2 ☑ No Yes, Give ear or Dates:	1 🗆	Yes 2½∏No	Specify:			Specify: W	hite		
Completed by Funeral Director	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)	n npleted) college (1-4or 5+)	16a. Deceden (Give kin life. DO	t's Usual Occupa d of work done d NOT use retired,	ition uring most of wor	king	16b. F	Kind of Business/	Industry		
ខ្ល	1.2		Home	${ t maker}_{ot}$				n Home			
Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan			·			
۵,	John Robert Sava	-						Wilson			
	19a. Informant's Name/Relationship (Type. P				nd Number or Ru						
- 4	Nancy Quinn (dau 20a. Method of Disposition	ghter)			Cut Rd.	Date		ocation - City or	<del>- ·</del>		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)			on (Name of ory or other place mation		0/2010		myrna,	,		
	21. Signature of Funeval Service Licensee	M005	22. N Ga	ame and Addres	s of Facility uneral	Home o	of S	tephen	L Schaech 21635		
	23a. Part Inter the risease, or complication		Do not enter t	he mode of dying	g, such as cardiac	or respiratory	arrest,	a, mb.	Approximate Interval Between		
	23a. Fart Inter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, simple of the control of the con										
	resulting in death)	Due to (or as a conseque		a, car	Cirone						
	Consumate the tipe constitutions										
ne	Sequentially list conditions, if any, is diffigure to him solutions. If any, is diffigure to him solutions. Solutions of the cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a nonseque	ance off:								
cam	Cause (Disease or injury that initiated events c	Due to feed a									
<u>س</u>	Toodhing III doddiny Eddi	Due to (or as a conseque	ence or):								
Medical Examiner	d										
Completed by Physician/Me	in the past 12 menths?	yes, outcome of pregnar  Live birth 2 Fetal  Pregnant at time of de  Unknown	death 3□E	ctopic pregnancy ther (specify)				23d. Date of del Month	ivery Day Year		
by P	Part II. Other significant conditions contribut	ting to death but not resul	ting in the unde	rlying cause give	n in Part I.		tobacco Yes 2	_	the cause of death?		
eted							res 4	, NO 3 P	obably 4   Olikilowii		
omble					·	24a. Was auto perfe	psy ormed?	prior to death?	itopsy findings available completion of cause of 2 No		
Bec	25. Was case referred to medical examiner?				26. Place of Dea				2 (2140		
	1 Yes 2 No Hospit	1   Inpatient 2   E	R/Outpatient	3 □ DOA Othe	r: 4 🗆 Nursing H	ome 5 7 Res	idence	6 □Other (Spe	cify)		
ü	27. Manner of Death 28 1 ☐ Natural 5 ☐ Pending	Ba. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how inju	iry occurred			
cati	2 Accident investigation				es 2□No						
ert	4 Homicide determined 28	le. Place of Injury - At hon building, etc. (Specify)	ne, farm, street,	factory, office		28f. Location ( City or To			ıral Route Number,		
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner:										
ğ	29b. Signature and title of certifier	1		29c. License				ate signed (Monti	h, Day, Year)		
	> poberta Illant	elen MD		0005	3675		113	29/10			
	30. Name and address of person who comple	,		,							
	Robert Montele	one, M.D.	111 7	V. High	St. E.	lkton,	MD.	21921			
е	31. Date filed (Month, Day, Year)	32. Registrar's signatu	irg b			•					

State Registra

			Plea	ase Type or							_		_	ible.		
		For State		State of	Marylar		artment <i>rtificate</i>			and N	1ental Hy		711	10	031	063
		Registrar  1. Decedent's Name	e (First, Middle	e, Last)		001	incate	0, 0	Catif		2. Date of De				3. Time of	
Physicia Medic				Y HADDAWA		- <del></del>	_				Month 01	15 15		2010	11:4	<b>OP</b> M
Examin .'	er			n, give street and numb SPICE HOUS			4b. City, To		EAST			4c.	. County	of Death	ም	
Funeral		5. Social Security No			7. Age (In yrs. I	**	If Under		If Under Hours		8. Date of Bir (Month, Da		T		lace (State o	r Foreign
Director		213-24-10 Usual Residence of		T D W Z X F	89	Yrs.					05-07-	1920		M.	ARYLAN	D
yland f shov ed at	tor	10a. State	10b. County		10c. Cit	ty, Town or Lo	cation							10	Od. Inside Cit	
or 28a- notifi	Director	MD 10e. Street and Nun		ALBOT			WIT 10f. Zip (					10a Cit	tizen of M	Vhat Count		2 <b>X</b> No
with the s 23a c	Funeral	8808 CUM		ROAD					1676			rog. Oil		J.S.A.	•	
filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		11. Marital Status		12. Was Deced Armed For	ces?	S. 13.	Was Decede If Yes, specif	nt of His	spanic One	gin? (Spe	cify Yes or No- Rican, etc.)	. [	14. Race	e - America k, White, e	an Indian,	
s after ral", o	ed by	<ol> <li>Never Marri</li> <li>Widowed</li> </ol>		If You Give	-		1 ☐ Yes 2	<b>X</b> No	Specify:				Specify:	T	HITE	
2 hour <b>"natu</b> edical	Completed	(Spe		nt's Education est grade completed)		(Give	dent's Usual kind of work	done de		t of worki	ng	16b. K	ind of Bu	ısiness Ind		
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filed v al Hyg d othe	o Be	17. Father's Name (	First, Middle,					$\neg \neg$		er's Name	e (First, Middle	, Maiden				
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	입	19a. Informant's Na		CE MISTER		400 44 10					IVY N			7: 0	7.3	
d 2 sho alth an 1 27 is or traus		GEORGE L			SON						Route Number		Town, S	tate, Zip C	ode)	
t of He If item or othe		20a. Method of Disp	osition	3 Removal from	20b. l	Place of Dispo cemetery, cren	sition (Name	of			Date		ocation -	City or Tov	wn, State	
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		4 Donation 21. Signature of Fur	5 Other (	Specify)	WES	LEYAN					1-2010				ARYLAN	
permir Depar Impor any ir		21. Signature of Fur	The service of	7		F	ELLOWS	HARI	ELFEN	BEIN	& NEW	NAM I	FUNE MD 2	RAL B 1601	OME, I	P.A.
		25a. Part 1. Enter the shock, or hear	he disease of t failure List	r complications that ca only one cause on eac	h lino	th. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory a	rrest,			Approximate Interval Bety	e ween
Physician/ Medical		Immediate Cause ( disease or conditio resulting in death)		a	Gongi	rene,	Lef	P 10	owe v	ey	tremi	79		3	Onset and D	Death
Examiner			444	Due to (c	per as a consequence	revel	vasc.	ular	r di	3eo	e			3	0720	us
o d	Examiner	Sequentially list con if any, leading to im- cause. Enter Under	nmediate rlying	Due to (c	r as a conseq	uence of):	Park	0011	. An		tuemi			1	3074	10-15
executed an and rial-transit	Exar	Cause (Disease or that initiated events resulting in death) I	3	c. Due to (c	or as a conseq		arero	Cor	CIVC						J	
	dical			L <sub>d.</sub>			_									
ertifica ding ph se as th	Completed by Physician/Medica	IF FEMALE:		23c. If yes, outc	ome of pregna	ancv							20 d D-4			
leath o	iciar	23b. Was decedent in the past 12 r 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{1} \)	months?	1 🔲 Live E	irth 2 🗀 Feta ant at time of	aldeath 3 🛚	Ectopic pr Other (spe		/				Mor	e of delive nth	1	/ear
at the c d by th etache	Phys	9 Unknown	icant conditi	ons contributing to de		sulting in the u	ınderlyina ca	use aive	en in Part I	i.	23e Did i	obaccou	ise contri	ibute to the	e cause of de	eath?
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iw requisite been 2 shou	plete	Hyp	rev for	Auten J							24a. Was				sy findings a	
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sician; certifi irector	To Be	25. Was case referre examiner?  1  Yes 2	ed to medical No	Hospital:	npatient 2 🗆	FD/Out-ation	-t 2 \( \sigma \)	Othor	ce of Deat		ne 5 Resi		<b>IX</b>		hoeni	ico
ng Phy ter this neral d		27. Manner of Death		28a. Date o		28b. Time of injury		c. Injury work?	at		28d. Describe				позра	<u>.cc</u>
ttendii death. stor: A / the fu	Certificate:	2 Accident 3 Suicide	Investi 6  Could	gation not be	of Injury - At ho	ome farm etr	M eet factor/	1 🗆 ነ	Yes 2 🗆	_	28f. Location (	Ctroot and	d Numbo	e o e Durol i	Douto Numb	
al or A s after al Direct		4 🗌 Homicide	detern		g, etc. (Specif)		eet, lactory,	311106			City or To			r Or Hurai i	noute (Vallis)	er,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	☐ Medical I	Physician: To the be Examiner: On the basis	of examinatio	n and/or invest	tigation, in m	y opinior	n, death oc	curred at	the time, date	and place	, and due	to the cau	se(s) and mai	nner stated.
fo the within 2 fo the comple	ğ	only one) 3 29b. Signature and		Nurse Practioner: T	the best of m	y knowledge, o			time, date	and plac	e, and due to the			nner as sta (Month, D		
		De Russ	ull l	a. Silve	20		א	42	587			01-	-18	-20	10	
Dein		30. Name and addre	ess of person	who completed cause	of death (Iten	23a) (Type, F	Print)	D	E	asti	on Me	21	(00	1		
RS 10 Stat		31. Date filed (Monti	h Day Year)	2010 32. 5	gistrar's Signa	ture	2000	, , ,		( (	on M&		50			
Registra	ar		JAN 1	y ZUIU	new	p. 4	auri									

			For State	State of IV	larylan		artment of H tificate of L		and M				0	nanel.
			Registrar  1. Decedent's Name (First, Middle	e, Last)		Cer	uncate of L	<i>Jeann</i>		2. Date of De	Reg. No	o. <u>C</u> U I		03064
,	Physicia Medi	cal	JOHN	THEODORE		HUF						9, 20 ľ	0	Time of Death 6:54A M
-	Examir	ner	4a. Facility Name (if not institution SOUTHERN MARYI	-	_		4b. City, Town, or CLINTON	Location of	of Death			c. County of De		GE
	Funeral Director		5. Social Security Number 578-58-1830	1X M 0	ge (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir				(State or Foreign GTON, DC
pur	show d at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Loc	eation							nside City Limits
Maryla	28a-fs	Director		GEORGE	FOR	ESTVIL								Yes 2 □ No
with the	s 23a oi iust be	Funeral [	10e. Street and Number  3701 CRICKET A	VENUE			10f. Zip Code 20747				10g. Ci	itizen of What 0	,	
<b>036</b> rs after death	peparurent or result and wenter rigitate in progret.  Special properties 23 a or 28a-f sho mortorant if them 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☒Mar 3 ☐ Widowed 4 ☐ Divorcec	If Von Cive		If	Vas Decedent of Hi Yes, specify Cubar	n, Mexican	, Puerto R	ify Yes or No- lican, etc.)		14. Race - Am Black, Wh Specify:		,
<b>21215-0036</b> within 72 hours after	r than "natu the Medical	Completed		nt's Education est grade completed)  College (1-4 or 5	ō+)	(Give k life. DC	ent's Usual Occupa ind of work done d NOT use retired) PERATOR		of working	g		Kind of Busines	s Industry	/
yland 2	arked othe atic event,	To Be	17. Father's Name (First, Middle, I THURMAN HUFF	_ast)		DOB O	LIMITOR		er's Name (	(First, Middle,				
Baltimore, Maryland bermit. Page 1 and 2 should be filed Denaturent of Health and Montal Ho	m 27 is m		19a. Informant's Name/Relationsl			<u> </u>	g Address (Street a	nd Numbe. VENUI	r or Rural I E FOR	Route Number ESTVIL	r, City or LE ,	Town, State, Z MD 207	ip Code) 47	
timore	tant: If ite jury or oth		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		ce	emetery, crem	sition (Name of atory or other place NS CEMETE	ERY	Da 1-29-	2010	CHE	ocation - City o	M, M	
<b>Bal</b>	Important in any in once.		21. Signature of Funeral Service I	icensee			Name and Addres					NERAL 1 20785	TOME	
	Sician,	82	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line	ð.		the mode of dying					SEACE	Inter	roximate val Between et and Death
	ledical aminer		resulting in death)	Due to (or as a	a conseque	ence of):								
ited	ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury	Due to for acid	I Gungaque	ende on:								
<b>60</b> ate be execu	g physician and is the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of);								
6876 ertificat	ding ph se as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	icv								
VITAI HECOTGS, P.O. BOX 68760 ysician: The law requires that the death certificate be executed	been signed by the attending should be detached for use as	Completed by Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	<u>-</u>				23d. Date of de Month	Day	Year
dS, P.C	n signed b uld be deta	ed by P	Part II. Other significant condition		ut not resul	Iting in the un	derlying cause give	en in Part I.				se contribute to		se of death?
Hecor	ate has bee	Somplet	DIABERTES	Malliatus						24a. Was a autop:	sy med?	prior to death?	completi	idings available on of cause of
Ital	certifica rector, p	Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:				ce of Death	(Check o	1  Yes	2 No	ol I □ Ye	s 2 🔊	NO
OT V	fter this ineral di	ite: □	27. Manner of Death	28a. Date of injur	y 2	R/Outpatient 28b. Time of injury	3 DOA 28c. Injury : work?	_4∟∫Nur at		e 5 🗌 Reside d. Describe ho		Other (Spec	cify)	
UIVISION OF VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death.	rector: A	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ation of be	ry - At hom		M 1 □ Y	'es 2□1	-			l Number or Ru	ıral Route	Number,
Spital o	neral Di		29a. Certifier 1 Tertifying	Physician: To the best of r	ny knowler	dge, death oc	cured at the time.	date and pl	lace, and c	City or Towr	20(0) 000	d manner as st	ated	
o the Ho	o the Fu	Medical	(Check 2 L Medical Ex	kaminer: On the basis of ex Nurse Practioner: To the b	amination a	and/or investig	ation in my opinion	, death occ time, date a	urrod at the	e time, date an and due to the	d place, cause(s)	and due to the and manner as	cause(s) a stated.	
	F 5		0	naly mo	>		150 6 8	s 9		2	0 I	e signed (Mont	n, Day, Ye	ear)
p	. 1		30. Name and address of person w	ho completed cause of de	ath (Item 2	23a) (Type, Pri	nt) ANILIC	MA	TAR	An-m	0 ,	SUNTH	ERN	MARYLAN
R	State Registra	e s	HOSDITAL (ENTO B1. Date filed (Month Day, Year) JAN 2 5 2010	Beneral 32. Register	's Signatur		F VF7) (	LINT	VIV I	·//// ~	14.	· )		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 9 2010 Ye ai Delores Adele Holmes **Physician**  $12:02A^{4}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Cheverly Prince Georges Hospital 9. Birthplace (State or Foreign Country)

1 Wash., DC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 2 7. Age (In yrs. last birthday) 5. Social Security Number 5 7 9 - 5 4 - 3 2 9 7 6. Sex **Funeral** 1 □ M 2 1 F Months Days Hours Min. 1941 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No ral", or items 23a or 28a-f sh Extinitions in ust be notified MD Prince Georges Capital Heights Completed by Funeral Director 10f. Zip Code 20743 10g. Citizen of What Country? 10e. Street and Number 6806 Sisalbed Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 □Yes 2 ☐No Specify: Black Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gonzaga Highschool Switchboard Receptionist Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Corrine Brown Edgar White ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6806 Sisalbed Dr. Capital Hts., MD 20743 Melvin Holmes, Sr./ Spouse item 27 Baltimore. 20b. Place of Disposition (Name of MD vertery, crematory or other place)
MD verterans cem. 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages
Department of
Important: If it
any Injury or o Burial 2 Cremation 3 Removal from State 21,2010 Cheltenham, MD Jan. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pridgen Funeral Service, PA 21. Signature of Funeral Service Licensee nawana 20706 9013 Annapolis RD Lanham, MD 23a. Part 1. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Heart ungestive disease or condition resulting in death) /Medical Due to (or consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dige to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 1 ☐ Yes 2 ☐ No 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 15 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

State

30. Name and address of persor

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who completed cause of death (Item 23a) (Type, Print)

32. Registar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar FH. TCHD. 1/21/10. r1s Certificate of Death Amended#8 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELWOOD R. JACKSON, Jr. JANUARY PS 2010 6:16 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 907 RADIANCE DR DORCHESTER CAMBRIDGE **Funeral** Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 11 MARCH 12, Year) 949 8. Date of Birth 9. Birthplace (State or Foreign Months 1 **X** M 2 □ F Hours MARYLAND **Director** 218-48-6760 60 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hygiene. Start, If item 27 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND DORCHESTER CAMBRIDGE 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 907 RADIANCE DRIVE 21613 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 X Never Married 2 Married 2 X No 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed and Mental Hygiene.

s marked other than "natural umatic event, the Medical E Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) RADIO BROADCASTING life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DISC JOCKEY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ ELWOOD R. JACKSON SARAH M. SULLIVAN 19a. Informant's Name/Relationship (Type, Priot) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA GLENDINNING/OTHER 907 RADIANCE DR., CAMBRIDGE, MD 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State CHESAPEAKE CREMATION JAN. 19, 2010 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
Months Immediate Cause (Final Physician/ LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? ate has been signed by the atte page 2 should be detached for Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate 1 🗌 Yes 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c, License number 29d. Date signed (Month, Day, Year) D39887 JANUARY 15, 2010

RS 3

DAVID H. SMITH, MD 8221 TEAL DR., STE. 301 EASTON, MD 21601

**1**9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03067 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 15:20 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death 9406 48th Avenue College Park Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days M 2□F 217-44-7836 63 Jan•18•47 MaryTand Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Prince George's College Park 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral 9406 48th Avenue 20740 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1967–1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian , or Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Engineer NASA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked John E. Kelly Pauline Effie Hill permit. Page 1 and 2 should Department of Health and Important: If item 27 is many injury or other traumsonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquelin H. Kelly -wife 9406 48th Avenue College Park, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Metropolitan Crematory 1/24/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Tinjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Luneral Director: After this certificate has been signed by the attending physicis the filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Yes 2 No ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 2 Accider
3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific

Registrar
DHMH 17 Rev 7/2009

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Name and address of person whip completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Mo

EN

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth Kain 10:43 Р.м 2010 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Bethesda Montgomery Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 New York **Funeral** 8. Date of Birth (Month, Day, Yea 1 M 2 T F Months Days Hours 578-44-2830 Director 98 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bethesda MD Montgomery 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6206 Verne Street 20817 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 ☐ Married ð altimore, Maryland 21215-0036 If Yes, Give Year or Dates ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker U.S. Government 5± Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P မ Unknown Edith Kain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7223 Marbury Court, Bethesda, MD 20817 Diane B. Savage/Friend permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State George town University January 14 Washington, D.C. 2010 Medićal Center 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Rd., Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ ARDIAL HKRYTHMIA IDAY **Medical** resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam signed by the attending physician and a be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death 4 Pregnant 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TRACT URINARY INF ECTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown completed filled in by the funeral director, page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? DEHYDRATION 24a. Was an autopsy performe Yes 2 X No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital 2 🗙 No Other: ဂ္ 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 11.0. D35941 01/13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. MATHUR 2 401 RESCARCH BLVD # 350 ROCKVILLE, MD 20850.

State

Registrar

31. Date filed (Month, Day, Year)

JAN 21

10:43 Pm

KAI S

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:25 HOMAS KING Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death VICON If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 335 Months Days Hours Min. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 Tho WD HEBRON Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21830 G373 CHERRYWALK RD NON 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1954 Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: 3 Widowed 4 Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FORMER AGRICULTURE LL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ THOMAS I KING SE ELNOTA SIMMIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. HEHRIETTA KING 6373 CHETTY WALK ND HEBREN AMD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ucomico memorial park cen. 1-22-2010 SOLISBURY med 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ryfenn Jeseich R MESSICKFUNERAL HOME PO BOX 6 BIVALUEI 100 DR14 meeris 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PHOWA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ficate be executed physician and the burial-transit ause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence (Cher (Specify) HOSPI CA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred

To the To the Comp

Medical

State Registrar

19 Natural

2 ☐ Accident
3 ☐ Suicia

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

Investigation 6 Could not be

determined

WAM

Brag 32. Registrar's Signature

injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work? 1 ☐ Yes 2 ☐ No.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Ruth Helen Lynn 10:50 PM Januaryao Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛚 F Months Days Hours Min 182-20-6196 West Virginia Director 84 Usual Residence of Decedent ifiled within 72 hours are...
ital Hygiene.
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show
event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 537 Frederick St. 21740 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Personnel Nursing Home permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ottany injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earnest Allen Lafollette Ollie Irene Lafollette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen S. Kennedy-daughter 217 Hebb Rd. Hagerstown, MD 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Mem. Park 1–25–2010 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) |Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Fastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebro vascuilai accident disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Drin to for as a consecute, pelot. To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary arter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check within 2 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) MID D0066116 1/22/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
AMJULEED ALL - 368 MILL STREET I SH-7 i Haparstown, MD, 21740-

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) JAN 25 2010

32. Registrar's Signature

		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death									
Physicia	ın/	Decedent's Name (First, Middle, Last)						2. Date of De	Reg. No.  2. Date of Death  Month  Day  You		3. Time of Death
Medic Examin		Gary James  4a. Facility Name (if not institution, give street and number)  Western MD Regional Medical Cente			nter		r Location of Dea			ty of Death Alleg	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	218-24-7924 <sup>1</sup> ⅓™ <sup>2□</sup> F		Age (In yrs. I 78		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.		. (Month, Da	rth	9. Birthplace (State or Foreign Country)  Maryland	
		MD Allegany			y, Town or Loc	cation umberland		10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
		10e. Street and Number 14 Blackiston Avenue						21502		Citizen of What Country? USA	
		11. Marital Status  1 Never Married 2 🖫 Marital 3 Widowed 4 Divorced	If Von Cive	es?	952- " 954 "	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 X No lent's Usual Occur	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Specif		white
		(Specify only higher Elementary/Seconday (0-12) 10	est grade completed)  College (1-4	or 5+)	(Give k life. DC	d Superv	during most of wo	orking	Plate		
		17. Father's Name (First, Middle, L Owen	Alvin	L	ayman		18. Mother's Na Edith	ame (First, Middle, Gold		-	ger
		19a. Informant's Name/Relationsl  Jeanette L. L			14 F	g Address (Street Blackisto	and Number or R on Avenu	e, Cumbe	rland,	MD 2	1502
		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	Specify)	tate C	emetery, crem nset Me	sition (Name of natory or other place emorial	Park 02/		20c. Location	rland	, MD
permi Depar Impo any ir		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Adams Family Funeral Home, P.A.  404 Decatur Street, Cumberland, MD 21502  23a. Part 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and disease or condition (resulting in death).								Approximate Interval Between Onset and Death	
		Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):								YEARS.	
		cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.									
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 🗀 Feta nt at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	ру			ate of deliv	ery Day Year
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the property of the									
The law req cate has bee page 2 shor		DISEASE						_ perfo	Was an autopsy performed?  Yes 2 ✓ No 1 ☐ Yes 2 ✓ No		
ttending Physician: The law death.  tor. After this certificate has the funeral director, page 2		25. Was case referred to medical examiner? 1   Yes 2   No								)	
	Certificate:	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	M 1 🗆								
pital or A		4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the terminal physician.					data and place	28f. Location (Street and Number or Rural Route Number, City or Town, State)  ace, and due to the cause(s) and manner as stated.			
o the Hos vithin 24 h o the Fun completed	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo							ue to the car nanner as st	use(s) and manner stated ated.	
6+		30. Name and address of person v	, 05	4004			1/29/2010				
M RS State	9	Shiv C. Kha	anna, M.D.	, 122	1 Natio	onal High	nway, La	Vale, MD	21502		
Registra		JAN 29 2010	Berus	1. 13	Barken						

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician EDITH D. MCLAUGHLIN <u>7:15</u>P <sup>M</sup> Jan. 25 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightview Assisted Living Bel Air Harford Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 K Months Days Hours 92 178-16-1283 7/1917 Director Michigan Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatilt and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or other traumatic event, Inc. Walled at any or other traumatic event, Inc. Walled at 1 ☐ Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 W. Ring Factory Road 21014 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify White \$ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker Public Schools 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert J. Draper, Sr. Bessie A. McKinnon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S.Duane McLaughlin/Son 64 Aubel Road, Delta, PA 17314 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition NBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Slate Ridge Cem. 1/28/2010 Delta, PA 21. Signature of Fuperal Service Licens 22. Name and Address of Facility C. Kobert Harkins Funeral Home, Inc., Delta, PA17314 23a. Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) congestore /Medical Due to (or as consequence of): Examiner Cardetruspel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenc \* f): I or Attending Physician: The law requires that the death certificate be executed and redeath.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burlar-transit in by the funeral director, page 2 should be detached for use as the burlar-transit Exami Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \ No 1 Tyes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in the Funeral Completely filled in the filled 29a. Certifier Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number David 30 235526 JANUARY 23, 20 FD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6

State Registrar 31. Date filed (Month, Day, Year)
FEB 0 4 2010

Dar i

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19, 2010 8:30 pM January William Preston Merryman 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Arcola Health & Rehab. Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 X M 2 □ F Feb. 12, 1929 D.C. 80 578-36-3874 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 10505 Huntley Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Noverried 2 😾 No 1 ☐ Yes 2 🙀 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 <u>Electrician</u> Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel M. Brown Mathew M. Merryman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10505 Huntley Place, Silver Spring, MD 20902 Margaret L. Merryman/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Tremation 3 ☐ Removal from State Metropolitan Crematory 2\$, Alexandria, Virginia Jan. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 Approximate or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be 2

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is its discal Examiner must be notified at

and Mental Hygiene.

Item 27

Pages 1

other t

Department of H Important: If Ite any injury or ot once.

attending physician and for use as the burial-tran signed by the a cate has page 2 s : After this certifications and director, p ours after death.

neral Director: Af

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner

Medical Certification: To

27 Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

30. Name and address of person who completed caus

Alan R. Segal, Md

31. Date filed (Month, Day, Year)

JAN 21 2010

determined

shock, or heart failure. List of	nly one cause on each line.			Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Disease  Due to (or as a consequence of):			Onco. and Doan
Sequentially list conditions, if any, leading to immediate cause (Disease or Injury that initiated events	b			
that initiated events resulting in death) Last	C			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of pregnancy  1		23d. Date of delive	ery Day Year
Part II. Other significant condition Coronary Artery	ns contributing to death but not resulting in the underlying cause given in Part I.  Disease			ne cause of death? pably 4 🕇 Unknowr
		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	prior to co death?	psy findings available mpletion of cause of
25. Was case referred to medical	26. Place of Dea	th (Check only one)		
examiner?	Hospital: 1   Innertient 2   ER/Outpatient 3   DOA Other:	ama E Decidence	e ClOthor (Casai	6.1

28c. Injury at Work?

D52261

Circle, Silver Spring, MD 20906

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 19, 2010

DHMH 17 Rev 1/2001

State Registrar

To the Hospital o within 24 hours af To the Funeral Di

10

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

1517 Hugo

Registrar's Signature

28a. Date of Injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charlton McCurdy Physician/ Philip 4:52 p<sub>M</sub> January 18, 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Hours sept. 21, 95 191 Director 218-10-9668 D.C. Usual Residence of Decedent 10a. State 10b. County with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits or 28a-f sl notified 1 🗌 Yes 2 🔀 No Maryland Montgomery Kensington 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 10311 Detrick Avenue 20895 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. White 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene.
27 is marked other than "
r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Plumbing & Heating Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked viury or other traumatic ev William Charlton McCurdy Anna Stull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10311 Detrick Avenue, Kensington, MD 20895 Margaret A. McCurdy/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 21, Jan. Department or Important: If any injury or 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, Virginia . Signature of Funeral Service Lice 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ute Medical resulting in death) Due to (or as a consequence of) Examiner S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the the attending phone IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Yes 2 No been signed by the g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 Yes 2 No Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗹 No Other: Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Hospital or Attending Pl 24 hours after death.Funeral Director: After the 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pendina work? 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 19, 2010 0 166300

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sujoy G. Tagore, MD 8600 Old Georgetown Road, Bethesda, MD 20814

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 per Inf G901 3/17/10 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar 03075 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Simone Maleh January 2010 7:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital ilver Spring Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours March 27 1 M 2 TXF Morocco 85 Yrs Director ,1924 096-28-8762 28a-f show 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 X Yes 2 □ No Silver Spring ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20906 12913 Layhill Road U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 → Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic. College (1-4 or 5+) Elementary/Seconday (0-12) Hairdresser Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Freha Cabalou Solomon Soussan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Gilmoure Drive, Silver Spring, Maryland 20901 Andre Berman/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Lebanon Cemetery 1-19-2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sep/ice Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction MChreMW MO15 Melissa Greenhut Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Acute or Chronic Renal Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) /sician and Exami Hospital or Attending Physician: The law requires that the death certificate be executed Altered Mental Status that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown ō Pregnant at time of death Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabeties Melatis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an Were autopsy findings available prior to completion of cause of Hypertension certificate has autopsy pade Hyperlipidemia performed? Yes 2 1 No death? 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 5 Pending 1 Natural 2 Accident work? s after death.

I Director: Af 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 3 L. Gertifying Nurse Practioner: To the best of my knowledge, deeth annumed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 068096 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JAN 21

M64

Satyam Shah, MD 1500 Forest Glen Road Silver Spring, Maryland 20910

3. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /		artment of F <i>tificate of L</i>		Mental Hy		010	03076
			Decedent's Name (First, Middle, Last	)			imouto or E		2. Date of De	Reg. No.		3. Time of Death
	Physicia Medic		Richard Bennett	MENTZER					)anva	Py 24	Year / 2010	0 9:57AM
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ار 			Washington Count 5. Social Security Number 6. Se	<del></del> -	1 (In yrs. last bii	eth day)	Hagers		C 0 D-1(D)	_	shing	
	Funeral Director		216-22-7801	VILLOUE	82	Yrs.	Months Days	Hours Mir	. (Month, Da	y, Year) 7 1927	Co	thplace (State or Foreign untry) rvland
	d t	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	ın or Lo	ation					404 1-14-07-11-7
	arylan a-fsh fied a	Director	Maryland Washingt	on			town					10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	or 28		10e. Street and Number	OII	па	Sers	10f. Zip Code			10g. Citizen	of What Co	
	with 1 s 23a ust b	Funeral	17521 Gay Street				2174	40		_	SA	,
	death items ier m		11. Marital Status	12. Was Decedent Ex Armed Forces?	ver in U.S.	13. V	Vas Decedent of H	ispanic Origin? (	Specify Yes or No-	14. F	Race - Ame	rican Indian,
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 🕅 Yes 2 🗆 N If Yes, Give Year or Dates 19			Yes 2 X No		to riidari, etc.)	Spec	Black, White cify: <b>W</b> h	e, etc. hite
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and Sur	e filed ntal H ed ot	To B	17. Father's Name (First, Middle, Last)						ame (First, Middle,	Maiden Surna	ame)	
Ĕ	d Mer d Mer mark matic		Samuel Bennett Me  19a. Informant's Name/Relationship (Ty)		Tie			Alice				
E S	12 shullth ar 27 is r trau		Debra Jones - Nie	. ,	i		g Address (Street a					· ·
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Baltimore,	epartr epartr nports ny inji		21. Signature of Funeral Service License	ie			. Name and Addres		Minnich :		-	
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90	physic the b	edical	•	d								
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Box	death he atter	Physician/M	in the past 12 months? 1  Yes 2  No	4 Pregnant at			Ectopic pregnanc Other (specify)	у			Month	Day Year
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σ,	ss that igned be de	þ	Part II. Other significant conditions con	tributing to death bu	t not resulting	in the ur	nderlying cause giv	en in Part I.				the cause of death?
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ř	n: The ificate or, pag		25. Was case referred to medical		,		00 DI		1 Yes	2 40		2 🗆 No
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<u>0</u>	tendil death. tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 No		_		
Division of Vital Records,	l or At after Direc	Sed	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, fa (Specify)	ırm, stre	et, factory, office		28f. Location (S City or Tow		nber or Run	al Route Number,
_	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	edical	29a. Certifier Certifying Physi	cian: To the best of m	ny knowledge,	death o	ccured at the time,	date and place,	and due to the car	use(s) and ma	ınner as sta	ited.
	the H hin 24 the Fu	Σ	only (ne) B L Certifying Nurse	er: On the basis of exa	est of my know	or investi rledge, d	gation, in my opinio eath occurred at the	n, death occurred time, date and p	at the time, date a lace, and due to the	nd place, and e cause(s) and	due to the c manner as	cause(s) and manner stated. stated.
_	<b>2</b> wit <b>2</b> €		29b. Signature and title of dertifier	511			29c. License	number		29d. Date sign	ned (Month	Day, Year)
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5 F	15+1		30. Name and address of person who co	(AM)(	aun (item 23a))	iype, Pr	HADE	RSTOWN	NMO	21	174	۷
h	Stat Registra	~	31. Date filed (Month, Day, Year)  JAN 96 20	32. Registrar	's Signature	1						
			JAM RV (U	IU a south	Marie Marie	400						

Amend Item 31 State of Maryland / Department of Health and Mental Hygiene

1 - State WCHD/SH per VR

Continued To Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Tanuary Physician/ ANC Medical 4a. Facility Name (if not institution, give street and number City, Town, or Location of Death Examiner 4c. County of Death Washington COUNTY WASHIND erslown 5. Social Security Numbe 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 80 Months Hours Min. 3-30-1929 216-26-8633 Director Usual Residence of Decedent Show 10a. State 10b. County 10c, City, Town or Location Rig Pool ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Washington MD 1 🗌 Yes 2 🖳 No 10f. Zip Code 10g. Citizen of What Country? 12708 Pecktonville Road 21711 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🂢 No Specify: "natural", 3 ♥ Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working residence permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Fillmore Gladhill Millard Mary Margaret Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12653 Parkhead Road Big Pool, MD 21711 19a. Informant's Name/Relationship (Type, Print) Gary R. Mills son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Parkhead Cemetery Big Pool, MD 2009 21. Signature of Funeral Service Licenses Name and Address of Facility Thompson Funeral Home, Inc O. BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final END Stose Ph sician/ osldic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner equirationly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHOONIC certificate has autopsy Heurs effusion
25. Was case referred t dical 1 Yes funeral director, l e 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: ပု V Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 XNatural . To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the funi injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 133 D00530 leted cause of death (Item 23a) (Type, Print) 21790 State

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State Registrar	1 10430	State of		nd / Depa	artmen	t of H	lealth a		tental Hy			0307	8
							Cei	rtificat	e of l	Death			Reg. No.			
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	/Medic	100	Paula Sti					1				Jan.	21	2010		0ă
1	Examin	er	4a. Facility Name (II			mber)		4b. City,	Town, or	Location of	of Death			unty of Deat	า	
			4 Hillc1 5. Social Security No			7 Ann (In uso	laat hirthday	E1kt		If Under	24 Hrs	9 Date of Die		ecil		
	Funeral Director		233 <b>-</b> 50-42		Sex 1□M 2□F	7. Age (In yrs	77 Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da Dec. 1	v. Year)	9. Bini	nplace (State or Fountry)	reign
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Modical Exempler must be multified at	d by	3 □ <b>X</b> Vidowed		Year or D	ates:								W	hite	
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	Hygie ther int,		17. Father's Name (	(First. Middle, Las	····		поше	maker		18. Mothe	er's Name	e (First, Middle,		Home		
Maryland	d be ental red o	o Be	Paul V.											,		
<u>Z</u>	should nd Me mark mati	2	19a. Informant's Na		-		19b. Mailir	na Address	(Street a			Law I Route Numbe	ar City or Ti	own State 7	in Code)	
	nd 2 stranger tranger		Sara M. E					-				on, MD	1,000		,,,	
ē,	Hea Hea Hea Hea Hea Hea Hea	1 (	20a. Method of Disp	position			Place of Dispo	sition (Nan	ne of		. [	Date		L tion - City or	Fown, State	
5	age ent o ht: if	- 1	1 ABurial 2 Donation		☐Removal from		cemetery, crer 1pin M	-				/2010	F1k+c	on, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be notified as once.	1	21. Signature of Fu		-078	/	22	. Name an	d Addres	ss of Facilit	hv			-		
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			23a Part1. Enter th	ne disease, or co	mplications that	aused the dea									Approximate	
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6	/Medical		resulting in death)	n .	a. Due to	(pr as a conse			4	-CV		١١١١١	_		7545	2
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Division of	ding h. After funei	tion	1 Natural	5 Pending investigati		of Injury th, Day Year)	Injury	M	8c. Injury Work	γαι ∢? Yes 2□		zou. Describe i	low injury o	ccurred		
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<u>&gt;</u>	after Dire	Certification;	4 🗌 Homicide	determine	build	ing, etc. (Speci	ify)	cot, factory	, ornos			City or Tov	vn, State)	0,710	, , , , , , , , , , , , , , , , , , , ,	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier	1 Certifying F	Physician: To the	best of mv kn	owledge, death	occurred:	at the tim	ne, date an	d place	and due to the	Cause(s) an	d manner as	stated.	
	e Ho 24 h e Fui letely	Medical	(Check only one)	2 Medical Ex	aminer: On the b	asis of examination	ation and/or in	vestigation,	in my or	pinion, dea	th occurr	ed at the time,	date and pla	ace, and due	to the cause(s)	
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			30. Name and addre	ess of person wh	o completed caus	se of death (Ite	m 23a) (Type.	Print)	7~1,	10	V		1 ONL	~erry >	21,201	
10			/ his	12. Hi	> Na	+ =	-11	NC	N	$\Delta N$	. 7	1192	1			
	Sta	te	31 Date filed (Mont	th, Day, Year)	32. F	te strar's Sign		-	-2							
	Registr	ar		JAN 2 2	ZUIU A	ener	p. A	TAK								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #29d = State Registrar MD, TCHD, 1/19/10, rls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 01 Physician/ GLEASON ELLIOTT MAXWELL 16 2010 10:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TALBOT HOSPICE HOUSE EASTON TALBOT 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) **GA** 7. Age (In vrs. last birthday) Funeral Months Days Min (Month, Day, Year) 2-31-193] 1 X M 2 D F Yrs. Director 260-44-0916 78 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1
▼ Yes 2 □ No EASTON MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21601 1013 NORTH WASHINGTON STREET 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ 1 XYes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) MINISTER RELIGION 12 marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 ERNEST EUGENE MAXWELL LOIS ELLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to REV. G. KEITH MAXWELL/SON 205 TUBMAN DRIVE, EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date ■ Burial 2 Cremation 3 Removal from State CARROLL MEMORY GARDENS 1/21/2010 CARROLLTON, GEORGIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. JOHN R MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the instructions that caused the death. Do not enter the instruction of the cause of the Sonset and Death Immediate Cause (Final Physician/ IRRHOSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and -transit that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical certificate be Box 68760 attending pl IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 2 No the 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate h 2 🗌 No 1 Tes Yes 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be 2 A No Hospital Other: 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\overline{x}$  Other (Specify) hospicethis Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Ă Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one Signature and tit

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Registrar
DHMH 17 Rev 7/2009

erson who completed cause of death (Item 23a) (Type, Print)

9120 MARKET ST; DENTU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Mitchell 21 7:40 P January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Derwood Montgamery **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 <del>Q</del> M 2 □ F Hours Min. (Month, Day, Director Kansas 213-48-7142 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Montgomery <u>Burtons</u>ville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20866 4605 Sandy Spring Rd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Completed Specify: 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Contractor other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name *(First, Middle,* Bessie Marks Maiden Surname) and Mental F is marked o permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ange. Larry Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4605 Sandy Spring Rd. Burtonsville, MD 20866 Kate Mitchell (Wife) Baltimore, 20a. Method of Disposition Jan. 28,201 North Lauderdale, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oueen of Heaven Cem. Florida 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral ! 9013 Annapolis Rd. Lanham, MD 20706 aw Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Colon Cancer with Metastatis disease or condition Medica resulting in death) Due to (or as a consequence of): <sup>1</sup>Examiner Sequentially list conditions, Examine if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed wn Be

or Attending Physician: The law requires that the death certificate be executed this certificate has been siral director, page 2 should I Director: A the Funeral D The Funeral D

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Certificate:

Medical

-		****			1 🗆 Yes 2 [	□ No 3 □ Probably 4√√ Unknow
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
2	25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)	
L	1 ☐ Yes 2 X No	Hospital: 1  lnpatient 2	ER/Outpatient 3	DOA Other: 4 X Nursing	Home 5 ☐ Residence 6	Other (Specify)
2	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	
	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e Dinco of Injuny At h		ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,

M033755

January 22, 2010

City or Town, State)

29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Rd. Derwood, MD 20855 Bindu, Joseph

31. Date filed (Month, Day, Year, State JAN 2 5 2010 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of Marylan	d / Depa Cer	artment of H <i>tificate of D</i>	lealth and M Death		giene / Reg. No.	2010	03081
			Registrar  1. Decedent's Name (First, Middle, Last,	)		timodito oi z	-	2. Date of Dea	ath		3. Time of Death
	Physicia Medic		Erna Lella Murray					Month 1	/14/2	010 Year	6:00 A M
	Examin		4a. Facility Name (if not institution, give s	treet and number)			Location of Death		1	ounty of Death	
			902 Karlson Avenue  5. Social Security Number   6. Sec		ast hirthday)	Hyattsvi If Under 1 Year	lle If Under 24 Hrs.	8. Date of Bir		nce Ge	orge's hplace (State or Foreign
ı	Funeral Director		325-18-3736	M 2 🔀 F 88	Yrs.	Months Days	Hours Min.	(Month, Da 9/19	$\frac{1}{1921}$	Dec	atur, Illinoi
	nd thow at	l. I	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation			_		10d. Inside City Limits
	//ary/a // Ba-f // tified	ect	MD Prince G	eorge's Hya	ttsvil	.1e					1 🔀 Yes 2 🗌 No
	a or 2 be no	اڇَا	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Co	
	th with	Funeral Director	902 Karlson Avenue	12. Was Decedent Ever in U.S	6 112.1	20783	enanic Origin? (Spe	cify Yes or No-	1.	U.S.	
980	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show other than medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	- 1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🕱 No		Rican, etc.)		Black, White	
9	hours natura lical E	lete	15. Decedent's Ed	ucation		dent's Usual Occupa kind of work done o		ina	16b. Kind	d of Business	Industry
21215-0036	within 72 giene. ner than " t, the Mec	Completed	(Specify only highest grades) Elementary/Seconday (0-12) 12	College (1-4 or 5+)	Bookk	O NOT use retired)	uning most of work	ng .	T or	firm	
	filed wit al Hygie d other event, th	l as l	17. Father's Name (First, Middle, Last)		DOOKK	.eeper	18. Mother's Nam	e (First, Middle,			
Jan	be fill lental rked dic ev	은	Ernest Watkins				Lella Ma	ry Drag	300		
Maryland	2 should be file lth and Mental   27 is marked or r traumatic eve		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Numbe	er, City or To	own, State, Zip	Code)
	0 = N =		Katherine S. Clark			arlson Av		attsvil Date		D 2078 ation - City or	
סר	_ 0		1 Burial 2 X Cremation 3	Removal from State	cemetery, crei	matory or other plac	e) 1/21	/2010		•	
Baltimore,	permit. Page Department Important: I any injury or once.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service License			Ltan Cremato 2. Name and Addres	ory				, V <u>irginia</u> more Avenue
B	permit. Departr Imports any inji		Kyanthe ca	4 Reachs						tsvill	e, MD 20781
			23a. Part 1. Enter the deease, or comp shock, or heart failure. List only or	lications that caused the deat ne cause on each line.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Coronary		Disease					20 years
-	Examiner		resulting in deathy	Due to (or as a conseq Hypertens							20 years
		iner	Secure tally list nonctions if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq						75	
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events	c							
	ate be executed bhysician and the burial-transit	<u>E</u>	resulting in death) Last	Due to (or as a conseq	derice oi).						
760	physics the l	ledical		d							
Box 687	ath certific attending p for use as	an/N	23b. Was decedent pregnant	23c. If yes, outcome of pregnative 1 Live Birth 2 Live Fet	aldeath 3 [		су		2	3d. Date of de	ilivery Day Year
Bo	Attending Physician: The law requires that the death certificate be executed or death.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity.	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				Month	Day
P.O.	requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
Js,	luires l en sigr uld be	ed b	Alzheimers Disea	ise				1 🗆	Yes 2 🖸	\$No 3□F	Probably 4 Unknown
cor	has bee	plet						24a. Was auto	s an opsy formed?	24b. Were au prior to death?	itopsy findings available completion of cause of
Re	Physician: The lav r this certificate has ral director, page 2							1 🗌 Yes	2 X No		s 2 No
/ital	sician certifi irector	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	T FR/Outpatie	_ Oth	lace of Death (Checer: 4  Nursing H		idence 6	Other (Spec	cify)
of V	g Physer this	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury		y at	28d. Describe			33)
ion	eath. or: Aft the fur	ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b			M 1 🗆	Yes 2 □ No				I D. A. Atlantan
Division of Vital Records,	il or Att	Cert	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, st fy)	treet, factory, office			(Street and wn, State)	Number or Hu	ıral Route Number,
ы	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical Certificate:	Chook 2 Medical Evam	sician: To the best of my knowner: On the basis of examinations Practioner: To the best of n	on and/or inve	stigation, in my opini	on, death occurred a	at the time, date	and place,	and due to the	cause(s) and manner stated.
	To th withir To th comp	-	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Mont	th, Day, Year)
			1/1			D0001	1601		Janu	ary 14	, 2010
R	8		30. Name and address of person who of Frank C. Blackbur	completed cause of death (Its	w 23a) (Type, Wisco	Print) Onsin Ave	., Ste. 6	75, Che	vy Ch	ase, M	D 20815
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 2 2010	Se. Registrar's Cign							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Margaret Morris January 14 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death 13901 Briarwood Drive #721 Prince Georges Laurel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Director 225-60-1029 65 June Usual Residence of Decedent shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13901 Briarwood Drive #721 United States 20708 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Parke Regester Jr Virginia Gregory Cardwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 Kipling Parkway <u>DeAnn Lawrence/daughter</u> injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1/26/10 Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery Crownsville, Md 22. Name and Address of Facility Hodges & 910 Silver Hill Rd., 21. Signature of Funeral Service Licenses Edwards F.H. Suitland, Md. 20746 3910 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shorty, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? <u>۾</u> 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ဂ္ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2

State Registrar

only one) 29b. Signature and title of certifie

JAN 2 2 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death D. Evelvn Macon 14, 1:18 A M January 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Washington Adventist Hospital Montgomery Takoma Park Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕏 F Months Days Hours Min. 12/11/1918 579-24-0549 Washington, DC Usual Residence of Decedent 10h County 10c. City. Town or Location 10d Inside City Limits 11√ Yes 2 No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Upshur St. NE 20017 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 🔀 No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookbinder Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Davis Rebecca Zilkes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas M. Macon / Spouse 1004 Upshur St. NE Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 1/19/2010 | Brentwood, MD 21. Signature of Funeral Service licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 23a Part 1. Enter the dise Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail r. List only one cause on each line immediate Cause (Fin SEPTIC SHOCK disease or condition resulting in death) Due to (or as a consequence of) ENAL ACUTE FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) DEMENTIA Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☑ No 1 ☐ Yes 2 3 10 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

**Physician** /Medical Examiner Examine and Box 68760,

**Physician** 

/Medical

Examiner

10a. State

DC

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Funeral

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Completed

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**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, The Medical Examination used to a sufficient and a superior of the real matter of the matte

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

Baltimore, Maryland 21215-0036

attending physician a for use as the burialby the signed I

Physician/Medical

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Completed

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Certification: To

Medical

4 Homicide

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29a. Certifier

that the death certificate be executed nours after death.

neral Director: Af

filled in by the fur

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of Vital Records,

Division Hospital or Attending 24 hours a To the Hosp within 24 hor To the Fune completely fi 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier HAMIN

29c. License number 1-59284

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 01/21/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WACHINGTON ADVENTIST HOSP, TAXOMA PARK, MD-20912 SHAMAD SLAMIM, MD 32. Registrar's Signatu (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patrick Irving McAllister January 19, 2010 12:36 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8263 Shire Drive Berlin Worcester 5. Social Security Number 8. Date of Birth (Month, Day, Year) 07/26/1934 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7, Age (In vrs. last birthday) Funeral 1 X M 2 D F Days Hours 75 173-26-5673 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Berlin Maryland Worcester 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21811 Funeral 8263 Shire Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: white 3 Widowed 4 K Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 machinist Dresser Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marion Lee German Irving Norwood McAllister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8263 Shire Dr., Berlin, MD 21811. Carol Green/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Salisbury Crematory Salisbury, MD Signature of Funeral Service Licensee 22, Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 air H monde 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Tancreatic Physician/ Metatastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of): If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inversid record; page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XNo 2 🗌 No 1 Tes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature nd/fittle of certifier 29c. License number 58755

Registrar DHMH 17 Rev 7/2009

State

714

31. Date filed (Month, Day, Year) JAN 21

30. Name and address of person who completed cause of death (Item 23a) Type, Print)
9714 Healthway Anne Berl

Healthwa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03085 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NAVALANEY MARGARET CATHERINE Physician/ January 18°, 2010° 8:03A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 14732 Blackburn Road Burtonsville Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 83 Hours 1 M 2 X F 216-80-6422 Jume'i 2° 1926 Pennsylvania Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Burtonsville Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14732 Blackburn Road 20866 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home is marked other Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Michael Pollock Mary Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 Marguerita Avenue Glenn Dale, Maryland 20769 Mary Ann Jarvis -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Gate of Heaven Cemetery 1/22/2010 SilverSpring, Maryland 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Bonard Home, PA Lorded UB 4400 Powder Mill\_Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 12 9 ☐ Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes; Hypertension 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 No 1 Yes 2 No this certificate Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural injury 5 Pending s after death. 1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39793 January 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Christopher J. Mays,

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

M.D. 18111 Prince Philip Drive, #207 Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 03086 Certificate of Death Reg. No.--1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Mary Caroline Osborne January 2010 11:20 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NMS of Hagerstown Hagerstown Washington county If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Months Days Hours 218-14-2348 87 April 30,1922 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Maryland | Washington county Hagerstown 1 X Yes 2 □ No Director Pages 1 and 2 should be filed within 72 hours after death with the Inent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 237 Jefferson St. 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Reprsenative Bank & Trust Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James M. Osborne Minerva E. Hetzer Osborne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trauonce. Mark A. Smith, Sr.-Friend 233 Jefferson St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemetery 1-27-2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SIL End Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 010/10 Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner attending physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo မ 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed after death Director: / 24 hours a within 2

State

Medical

29a. Certifier

31. Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed

Day, Year,

Registrar

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

K12

29c. License number

29d. Date signed (Month, Day, Year)

OIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** IAM 20 ,2010 /Medical or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town Examiner Birthplace (State or Foreign Country) If Under Ade (In yrs. last birthday) Security Number Sex 1 AM 2 □ F **Funeral** Months Days Hours Min. MD 216-44-2353 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 🚈 No Director MD Rock Hall Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21903 Yerkey Rd. 21661 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ZNo 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White If Yes, Give Year or Dates: Specify: ğ Specify: 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Parks Emma McGraph ဂ္ permit. Pages 1 and 2.
Department of Health an.
Important: If Item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21903 Yerkey Rd. Rock Hall, MD 21661 Theresa K. Parks/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Cremation: 1/25/10 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nuntes disease or condition resulting in death) Cardiac /Medical Examiner artherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Box 68760. B Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 2 No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Willen, M.D. DZ1313 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

KINK, WUN,

31. Date filed (Month, Day, Year)

415 Washington

32. Registrare Signature

Ave, Chestertown, MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JÄNUARY <sup>Day</sup> 9 2010 PULLEY 5:30 P JUNE **JESSIE** Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 11100 TEABERRY WAY COURT CLINTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min JUNE 11 1944 NORTHY CAROLINA Director 65 <u>238-70-3096</u> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1x Yes 2 □ No CLINTON PRINCE\_GEORGE'S MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 IISA 11100 TEABERRY WAY COURT 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc Completed by 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) EQUIPMENT OPERATOR PRIVATE 9TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BEATRICE M. HALL JESSIE W. PULLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11100 TEABERRY WAY COURT CLINTON, MARYLAND 20735 BARBARA A. PULLEY/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 DeBurial 2 Cremation 3 Removal from State LINCOLN CEMETERY 1/25/2010 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) METASTATIC ESOPHAGEAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Other (specify) Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown n signed by t<sub>i</sub> Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed safter death. I **Director:** After this certificate h 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner?

1 Yes 2 Yo ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5  $\square$  Pending **X**Natural injury Accident Investigation ☐ Acciden 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital within 24 hours a To the Funeral C

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUTH HE M.D. 3800 RESERVOIR ROAD N.W. WASHINGTON, DC 20007 31. Date filed (Month, Day, Year)

JAN 2 5-2010

Medical

29a. Certifier

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D035046

29d, Date signed (Month, Day, Year) 1/02/2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death	19
	_		1. Decedent's Name (First, Middle, Last)  2. Date of Death 3. Time of Death	
	Physicia Medic		Jeffrey C. Rodkey JAMWARY 25, 2010 06:44F	<sup>1</sup> M
	Examin /	er	4a. Facility Name (if not institution, give street and number)  Saint Joseph Medical Center  4b. City, Town, or Location of Death Towson  4c. County of Death Baltimore	
I	Funeral Director		5. Social Security Number $178-48-4630$ 6. Sex $1 \times 10^{-1} \times 10^{$	ign
	and show at	or	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City Lim	its
	Maryla 28a-f	Funeral Director	PA Dauphin Harrisburg 1 🗆 Yes 2 🗵	No
	rith the 23a or st be r	ral D	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  7016 Fishing Creek Valley Rd. 17112 U.S.A.	
	1 and 2 should le filed with in 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is mar led other than "natural", or items 23a or 28a-f show other traumatile event, the Medical Examiner must be notified at		11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
036	s after ral", or Exami	ed by	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 News, Give Year or Dates. 1977	
15-0	72 hour "natu edical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working	
212	within giene.		Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Repairman McCormick Spice	
and	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Mabel R. Mader	
aryl	nould Ind Me s mari umati		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ž,	ind 2 st lealth a im 27 is		Kelly J. Bishop/Daughter 809 McIlhenny Ave. Harrisburg, PA 17112	
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of F Important: If ite any injury or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of However Place)  20c. Location - City or Town, State  20c. Location - City or Town, State  1 Dan Data 28,  Howes & Crematory 2010  Harrisburg, PA	
3altii	ermit. P epartm nportal ny injur		21. Singura / Furier / Sirvice Licepseg 22. Name and Address of Facility J.J. Hartenstein Mortuary Inc	
_	<b>C</b> □ = <b>e</b> ο	2	24 Second Street, New Freedom, PA 1734  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate	9
	Pnysician/	8 7	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition ACUTE MYDCARDIAL INFARCTION INFARCTION	
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):	
		iner	Sequentially list conditions, If any lee ling to immediate.  Due to for as a consequence of:	
g,	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):	
0	cate be executed physician and the burial-transit	edical E	d.	
3876	artificate ding ph	/Med	IF FEMALE: 23b. Was decadent pregnant. 23c. If yes, outcome of pregnancy	
Box (	death ce the attendance	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	
P.O.	that the red by t detach	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
ds,	equires sen sign	ted k	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unkno	wn
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed	24a. Was an autopsy performed?  1 □ Yes 2 ▼ No 1 □ Yes 2 ▼ No	
ita	Physician: T r this certifice aral director, p	Be	25. Was case referred to medical examiner?  Hospital:  26. Place of Death (Check only one)  Tother:	- 8
of <	ng Phys ter this neral di	te: To	27. Manner of Death 1	
sion	ttendir death. stor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	
Divi:	tal or Ars after al Direct		4 Homicide determined determined determined building, etc. (Specify)	
	e Hospi 1 24 hou e Funer	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ated.
	Vithii Comp		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	
	X		30. Name and aduless of person who completed cause of death (Item 23a) (Type, Print)	
	10.		JEFFREY J. BERNSTEIN, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204	•
	Stat Registra	e ir	31. Date filed (Month, Day, Year)  SZ:-Registrar's Signature  FEB 0 4 2010  Level A. Lorder	
_			A STATE OF THE PARTY OF THE PAR	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			1 - State of Maryland / Depar State of Maryland / Depar Cert	ificate of Death		2010	03090
	Physici		1. Decedent's Name (First, Middle, Last)  Rue Burke Stevenson		2. Date of Death Month January	14, 2010	3. Time of Death 9:58 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Wilson Health Care Center	4b. City, Town, or Location of Death Gaithersburg		4c. County of Death	
ave."	Funeral Director		Social Security Number     6. Sex     7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Sept. 7	_	hplace (State or Foreign untry)
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28	al Dire	10e. Street and Number 301 Russell Avenue	10f. Zip Code 20877	100	g. Citizen of What Col United St	
5-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ideal Evan in a must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	as Decedent of Hispanic Origin? (Sp /es, specify Cuban, Mexican, Puerto □Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
0-61212	filed within 72 ho Hygiene. other than "natur ent, Iro Medical	Completed	(Specify only highest grade completed) (Give ki	nt's Usual Occupation nd of work done during most of work O NOT use retired) Lons Specialist	ing	J.S. Gover	
land	d d d	To Be C	17. Father's Name (First, Middle, Last) William Armington Burke	18. Mother's Name Olga Joy	e (First, Middle, Ma Otis	aiden Surname)	
, Mary	12sh hand 7ism traum			Address (Street and Number or Runessional Drive Su		-	
saitimore,	Jes 1 t of H if iter		4 Donation 5 □ Other (Specify)   Medical Ce	sn. University 20 enter 20	an. 14 10 Wa	oc. Location - City or Tashington,	D.C.
Ball	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee /M00969 90	Name and Address of Facility Col 13 Annapolis Road	umbia Mon l, Lanham	rtuary Ser ,MD 20706	vices,P.A.
,	Physician	1 32	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ant Laile	100	st,	Approximate Interval Between Onset and Death
	/Medical Examiner			tery Lixias	u		
	ecuted and transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
08/00,	ificate be executed g physician and as the burial-transit	edical Ex	Due to (or as a consequence of):				
. Box	death certi e attending d for use a	Physician/Mec		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
ras, r	requires that the neen signed by th		Part II. Other significant conditions contributing to death but not resulting in the und Chronicatural felerillation.	erlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Hec Hec	The la ate has	Completed by	Stinasia Dementia	eg. Spinal	24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of 2 ☐ No
<u> </u>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othor	h <i>(Check only one)</i> ome 5 □ Residen	) ice 6	cify)
0	ng ffe	ation: T	27. Mann of Death  1 Mann of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how		
=	ੂ ਵੇਂ ਵੇਂ ਵ	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town,	eet and Number or Ru State)	ıral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investant manner stated.				
	North Withi To tl	M	29b. Signature and title of certifier  Le Robert Perschanges	29c. License number	29	d. Date signed (Monti	n, Day, Year) 4/4, 2010
7			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	int) 201 R4	ISSELL RSBUR	AVENGE GIRLS	20877
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 1 2010  37. Registrar's Signature	2			

		For State		State	of Maryla		artment of F rtificate of	lealth and M Death	lental Hy	-	2010	03091
		Registrar  1. Decedent's Name	e (First, Middle	e, Last)		- 00		Dealli	2. Date of De		_	3. Time of Death
Physicia /Medic		David	d Sep	ehrfar					Januar	y 12		7:55 A. M
Examin		4a. Facility Name (i	If not institution	n, give street and r	umber)		4b. City, Town, o	r Location of Death		4c.	. County of Death	
		Bethesda Her 5. Social Security N				er a. last birthday	Betheso	da If Under 24 Hrs.	8. Date of Bi		Montgomer	place (State or Foreign
Funeral Director		138-78-0		6. Sex 1 ☑ M 2 ☐ F	57	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	1952 Tehi	intry)
		Usual Residence of	f Decedent		140.6							10d. Inside City Limits
larylar shov	or	10a. State	10b. County	jomery		ity, Town or Lo ethesda						10d. Inside City Limits 12€ Yes 2 □ No
the Maryland 7 28a-f show notified at	rect	10e. Street and Nui		,			10f. Zip Code			10g. Cit	tizen of What Cou	intry?
23a or	al D	5721 Gro	svenor	Lane			20814			Unit	ted State	es
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Evaninar must be notified at	Funeral Director	11. Marital Status		Armed i	cedent Ever in l	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,	
rs afte	by F	1 ☐ Never Marr 3 ☐ Widowed		ied 1 ∏Yes If Yes, ( Year or	2 ⊠No 3ive Dates:		1 □Yes 2 <b>∏</b> No	Specify:			Specify: Wh	ite
2 hou			15. Deceden	t's Education		16a. Dece	dent's Usual Occup	pation		16b. K	(ind of Business/Ir	ndustry
ithin 7 ne. nan "n	Completed	Elementary/Seco			(1-4or 5+)	Disa	DO NOT use retired	during most of worki d)	ng		N/A	
Hygier Hygier Iher th	Col	17. Father's Name	(First Middle	I act)		DISa	pred	18. Mother's Name	(First Middle	e. Maiden		
ld be f ental I ked of	To Be		epehrfa					Fatemeh				
s mar	-	19a. Informant's N				19b. Mail	ng Address (Street	and Number or Run	al Route Numi	ber, City	or Town, State, Zi	ip Code)
and 2 ealth m 27 I		Maryam S		r/Sister				ferson St				
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Evanone.		20a. Method of Dis 1 ☐ Burial 2		3 ☐ Removal from	n State	Place of Disponentery, cre	osition (Name of matory or other place 1. Univer:	- 1 T- 0 00 - 00			ocation - City or T nington,	
artmer ortant Injury		42 Donation 21. Signature of Fu			Me	dical (	enter:	-, 201	-			vices, P.A.
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		23a. Part 1. Enter t	the disease, or art failure. List	complications that	caused the dea	ath. Do not en		ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final on	a	Cirho	1515	Of liv	ep				Onset and Death UNKNUWN
/Medical Examiner		resulting in death)		Due t	o (or as a conse	quence of):						
	Jer	Sequentially list co if any, leading to in cause. Enter Unde	nditions, nmediate	b	o (or as a conse	quence of):						
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be execian a	I Ex	resulting in death)	Last	Due t	o (or as a conse	quence of):						
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death	sicia	in the past 12 1 ☐ Yes 2 [	□No		e birth 2□Fe gnant at time o known		☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	;y 			Month	Day Year
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w req	Completed		al	les M	Sim				24a. Was		24b. Were aut	topsy findings available
The la	omo									opsy formed? 2 M No	death?	completion of cause of
clan: ertifica	Be C	25. Was case refer examiner?	rred to medical					26. Place of Deat		$-\Delta$		
Physic this c	၉	1  Yes 2 2 27. Manner of Deat			Inpatient 2	ER/Outpatie		4 Iti Nursing Ho			6 ☐ Other (Spec	ify)
ding th. After funer	Certification:	1 Natural 2 Accident	5 Pendin investig	g (Mo	e of Injury onth, Day, Year)	Injury	Wor	k?  Yes 2 □No	28d. Describe	now inju	ary occurred	
Atten ector: by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be 28e. Pla	ce of Injury - At ding, etc. (Spec	home, farm, st	reet, factory, office		28f. Location City or To			ral Route Number,
Ital or is after all Dir	Cert	4 - Hollifolde										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)		Examiner: On the				me, date and place, opinion, death occur				
To the within To the comple	Me	29b. Signature and	d title of certifie				29c. Licens	se number		29d. Da	ate signed (Month	ı, Day, Year)
			Chro	wdly				143/21		6	01/21/1	0
		30. Name and addi	ress of person	who completed ca	use of death (Ite	em 23a) (Type	Print) DINO D	PRIVE ;	BURT	ONS	SVILLE,	MD20866
Sta	te	31. Date filed (Mon	nth, Day, Year)	32.	Registrar's Sign	nature	-	-				
Registra	ar	J	IAN 21	2010	news	B. 19	arked.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		rtificate of			eg. No.	1 03092
ı	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dear		3. Time of Death
	/Medic		Charles	Frankli	in	Str		January	y 26, 2010	7:00 A.M.
	Examin	er	4a. Facility Name ( <i>If not institution, giv</i> e si 12806 Old Church I				or Location <i>o</i> f Death mberland		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia M 2□ F 84	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07/13/		egany rthplace (State or Foreign Jountry) aryland
	ס		Usual Residence of Decedent							
	arylar show	'n	10a, State 10b, County		, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	recto	MD Allegany  10e. Street and Number	7		Cumber 10f. Zip Code	land	1	0g. Citizen of What C	
	th with 23a or	ral Di	12806 Old Chur	ch Lane, NE			21502		USA	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy figury or other traumatic event, it is "Midfal Evandra", it is the pruffied at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No 194 If Yes, Give Year or Dates: 1011	3-	Was Decedent of H fYes, specify Cub I □Yes 2 🏋 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	te, etc.
5	2 hour atural	ted	15. Decedent's Educa	ation	16a. Deced	dent's Usual Occup	pation		16b. Kind of Busines:	White s/Industry
ה ה	hin 72 e. an "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retire	during most of work d)	ring		
7	ed wit ygien her th	Son	12			Salesma	I		Insuranc	е
yland	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Charles	Felix	Stro	ng.	18. Mother's Nam Minr		Maiden Surname) De 1.1	Northcraf
Ž	hould nd Me mark matic	၉	19a. Informant's Name/Relationship (Typ						r, City or Town, State,	
2	nd 2 salth ar 27 is r trau		Ruth Lee Strong /						mberland,	
ກັ	ss 1 ar		20a. Method of Disposition	20b. Pla		sition (Name of natory or other pla			20c. Location - City o	
Ĭ	Page ment ant: If ury or		1 🖾 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)				Park 01/29	9/2010	Cumberlar	nd, MD
Danimor	permit. Departi Import any Inj		21. Signature of Funeral Service Licensed	hm			ess of Facility Aduur Street			l Home, P.A. 21502
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.	<del></del>					Approximate Interval Between
٠.	Physician		Immediate Cause (Final disease or condition	ESOPHA						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
Š,	ж ехе sian al urial-t		resulting in death) Last	Due to (or as a conseque	ence of):					
0/00,	cate b	edical	d.							
מ אחם	nding suse as		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan					23d. Date of d	elivery
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnand Other (specify) _	су		Month	Day Year
cords, r	uires that signed I Id be det	ompleted by P	Part II. Other significant conditions cont CAD, ATRIAL NORMAL PRESS	ributing to death but not resul PIB RÎ UAT	Iting in the ur	PUD,	ven in Part I.	23e. Did to		to the cause of death?  Probably 4 Unknown
5	aw req	olete	NORMAL PRESS	WRE HUDRO	CEPH	tlus		24a. Was a	n 24b. Were a	autopsy findings available
ב -	The la ate ha page 2	Com						autops perfor	med?   death?	completion of cause of s 2 □ No
פ	cian: sertific setor,	Be (	25. Was case referred to medical examiner?			T-iii	26. Place of Deat		_	
5	Physical direction	<b>T</b> 0	1 Yes 2 No HG	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatier 28b. Time of	IL SELDOA			ence 6 Other (Sp	ecify)
5	nding ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	ryai rk? ]Yes 2 □ No	28d. Describe in	ow injury occurred	
	I or Atte after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Town	treet and Number or I n, State)	Rural Route Number,
	Hospita 24 hours Funeral etely filler	Medical C		ician: To the best of my know er: On the basis of examinati and manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mor	nth, Day, Year)
	3+		YVLE N. Clari	stand MD		D006	4167		January	26, 2010
	MR)		30. Name and address of person who con Noshin Qaisi				venue, Cu	ımberland	d, MD 215	02
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure .		,			
	Registra	ar	IAN 27 2010	A A	back	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar 03093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Barbara Lou Soyk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany **Examiner** Western Maryland Regional Med Ctr. Cumberland Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/16/1950 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛱 F Country) Marvland 212-54-8202 59 Director be filed within /2.1.—

Aental Hygiene.

arked other than "natural", or items 23a or 28a-ī 51.—

Aic event, the Medical Examiner must be notified at Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 218 Columbia Street 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail Be other traumatic event, 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Robert Reger Ione Louella Blackburn Earl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20105 National Highway, Frostburg, MD 21532 Tina Henson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 01/22/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Lie 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Conveto disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and I-transit that the death certificate be executed crku that initiated events resulting in death) Last g physician are the burial-t Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 9 ☐ Unknown 9 Unknown P.0. Par<u>t II</u>. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, as been signal to a should to Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2.8 autopsy perform death? 1 Yes 2 No Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No M 2 Acciden 3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bewerly Calkins, M.D., 600 Memorial Avenue, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) JAN 25

Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical Longer 1120 Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 05/15/1946 252-68-0035 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified once. Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 1994 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) aborer 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ker)701 irele ast Hord. usan Moyer 20b. Place of Disposition Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Dover 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bennie Smith MMMIE Immediate Cause (Final disease or condition resulting in death) **Physician** Multi System
Due to (or as a consequence of): Multi organ /Medical **Examiner** Interstitial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Prenal disease that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death
9 Unknown in the past 12 months? 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 | No 2 Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

BIVd 274 N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. To the Hospital or Attending Physician: The law requires that the death certificate be executed 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗌 No 1 Tyes 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred To the Funeral Director: After 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 TENDERCK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Iack

1 Yes 2 No

Year

2010

14. Race - American Indian,

Black, White, etc.

IS

		•	For State Registrar	Glate of Marylan		rtificate of	Death		Reg. No.	)   U	UJ	093
Ė			Decedent's Name (First, Middle, Last	it)				2. Date of Dea Month	ith Day	Year	3. Time	of Death
	Physicia /Medic		WILLIE LE	E TON	/LIN	JR		JANUARY			1002	M
200	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death			ty of Death	ODCE	
			PRINCE GEORGE HOS	SPITAL		CHEVERLY				CE GEO		
Т	Funeral		Social Security Number     6. S	ex 7. Age (In yrs. I	**	If Under 1 Year Months Days		8. Date of Birt (Month, Day	y, Year)	Cour		∍ or Foreig
	Director		267-68-1772	AM 20 F 65	Yrs.			9-13-19	44	GEORG	GIA	
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c Cit	v. Town or Lo	ecation				1	0d. Inside	City Limits
	aryla sho	5	MD PRINCE G		T PLEA						1 <b>∑</b> Y∈	es 2 No
	Ba-f	Funeral Director		ECKOL DE	11 1 2 2 2 2 2	10f. Zip Code			10g. Citizen o	f What Cour	ntry?	
	vith t	Ë	10e. Street and Number									
	s 23s	eral	6801 GREIG STREET	#103 12. Was Decedent Ever in U.	C 12	20743	Hispanic Origin? (St	necify Yes or No-	U.S	ace - Americ	can Indian.	
	er de	Ë	11. Marital Status	Armed Forces?	3.	If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	Rican, etc.)	BI	lack, White,		
	s aft	by F	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes <b>2√∑</b> No If Yes, Give Year or Dates:		1□Yes 2∏XNo	Specify:		Spec	cify: BLA	JK.	
3	hou itura				16a. Dece	dent's Usual Occu	pation		16b. Kind of	Business/In	dustry	
?	in 72 n "ne n "ne	plet	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give life.	kind of work done DO NOT use retire	during most of worled)	king				
7	with jiene r tha	Completed	9th	College (1-4or 5+)	MOV	ER			PRIV	ATE		
3	Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surna	ame)		
ğ	2 should be filed within 72 hours after death with the Maryland a and Memlat Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, It. Medical Evan	To B	WILLIE LEE TOMLIN	I SR			MARIAN TO	OMLIN		_		
2	shou ind N i mai	-	19a. Informant's Name/Relationship (	Type. Print)			et and Number or Ru				o Code)	
Ě	70 ± C =		OLIVIA MCKENZIE/A	UNT	816	52nd STR	EET NE WAS	SHINGTON	, DC 2	0019		
<u>ה</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Marical Evan in a natural banotified.		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other pla	ace)	Date	20c. Location	n - City or To	own, State	
2	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State		CREMATO		2-2010	RIVERD	ALE,	MD	
			21. Signature of Funeral Service Licer				ress of Facility JB					
בֿ	permit. Departr Importa any Inje		X. N. N.	1.000	7	474 LAND	OVER RD L	ANDOVER,	MD 20	785		
			23a. Part 1. Enter the disease, com shock, or heart failure. Lis only	plications that caused the deat	h. Do not en	ter the mode of dy	ring, such as cardiac	or respiratory a	rrest,		Approxim	nate Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq		KKI IIIIIII						
	Examiner			CORONARY		DISEASE						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq								
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	DIABETES	MELLIT	US						
5	execution and ital-tra	Exa	resulting in death) Last	Due to (or as a conseq	uence of):							
Š	rificate be executed ng physician and as the burial-transit			d								
9	tifical g phy as th	Aedical							-1			
5	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregna	nev			Date of deliv		
	deatl e atte d for	Physician/	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at time of		Other (specify)				Month	Day	Year
	t the by th ache	hys	9 ☐ Unknown	9 Unknown								
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č	The la	E							rmed?	death? 1 ∐Yes		,, 000000
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5	a Physerathic	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of			28d. Describe				
5		ig.	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio		linjury		⊡Yes 2 □ No					
20	I or Attending after death. Director: After I in by the funer	ij	3 Suicide 6 Could not b	20e. Flace of Injuly - At I	ome, farm, st	treet, factory, office	9	28f. Location ( City or To	Street and Nu	mber or Ru	ral Route N	lumber,
5	al or afte Dire	Certification:	4 Homicide	building, etc. (Speci	'97			Only or 10	viii, Olato)			
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 1 ☐ CertifyIng P	hysician: To the best of my kn	owledge, dea	th occurred at the	time, date and place	e, and due to the	cause(s) and	manner as	stated.	(a) as
	ie Ho ie Fu	Medical	(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/or i	investigation, in m	y opinion, death occ	urred at the time,	, uate and plat	Je, and due	to the Gaus	ro (3)
	To the within 2 To the Completed	Me	29b. Signature and title of certifier	1			nse number		29d. Date sig	ned (Month	, Day, Yea	r)
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	8.			to the discourse of all paths (the	00 \ (T	Dulad						

DHMH 17 Rev 1/2001

State Registrar WADE BRENNOM, MD 3001 HOSPITAL DRIVE CHEVERLY, MD 20785
31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Taylor David January 2010 1:55 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges 4714 Prince Georges Ave Beltsville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min (Month, Day, Year) 03/14/1936 Yrs Director 247-56-5590 South Carolina Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD. Prince Georges Beltsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4714 Prince Georges Ave 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Specialist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked ot ပ Louis Taylor traumatic Mamie Council 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Gloria Taylor / Wife 4714 Prince Georges Ave., Beltsville, MD. 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/26/2010 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature Funeral Service D Marces 3401 Bladensburg Rd., Brentwood, MD It 1. Enter the discrete, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Year Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Directo for an electrication de of physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending photostate the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 1 Yes 2 9 Unknown ate has been signed by the page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I autops 1 Yes 2 No Yes 2 X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 🕱 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: e Hospital or Attending P 124 hours after death. e Funeral Director: After t 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a, Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) D47654 1/21/2010

Registrar
DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore.

Box 68760

P.0.

Records,

Division of Vital

110 Irving St., NW #GB10 Washington, DC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlotte K. Dean, MD 110 Irving St..

Charlotte K. Dean,
Date filed (Month, Day, Year)

JAN 2 2 2010

21814 White Oak Road Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Dec 11, 19 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🕱 F 424-72-5927 Director 60 Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho the "Accided Examiner nast be notified at Director Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21814 White Oak Road 21740 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the "Moder Examiner in ust any injury or other traumatic event, the "Moder Examiner in ust any once. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Moselev Nellie Frances Crane ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21814 White Oak Road Hagerstown, Maryland 21740 William A. Winkler / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 01-27-2010 | Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 21. Signature of Janeral Solvice Licens 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 21713 23a. Part 1. Inter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Immediate Cause (Final disease or condition resulting in death) **Physician** andio pulmonan /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Due to (or as a consequence Division of Vital Records, P.O. Box 68760, Physician/Medical

Moseley

Winkler

1. Decedent's Name (First, Middle, Last)

Eloise

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2

4b. City, Town, or Location of Death

2. Date of Death

January

22

1949

2010

4c. County of Death

U.S.A.

Specify:

Retail

14. Race - American Indian, Black, White, etc.

White

Washington

3. Time of Death

Α

9:55

Birthplace (State or Foreign Country)
 Alabama

10d. Inside City Limits

Onset and Death

Year

Years

1 ☐ Yes 2 X No

Be	25. Was case referred to medical examiner?		26. Place of Death (Check only	one)
2	examilier/ 1 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Home 5 Re	sidence 6 ☐Other (Specify)
	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work?  1 Yes 2 No	e how injury occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be determined		tory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State)
Medical	29a, Certifier (Check only one)  Certifying P	hysician: To the best of my knowledge, death occu miner: On the basis of examination and/or investige and manner stated.	rred at the time, date and place, and due to the stion, in my opinion, death occurred at the time	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)
5	20h Signature and the of certifier		29c License number	29d Date signed (Month Day Year)

and manner stated 29b. Signature and of certifier

29d, Date signed (Month, Day, Year) 044996

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CÓH-4 State Registrar

within 24 hours a

To the Funeral t

completely filled

Completed by

31. Date filed (Month, Day, Year)



Medica Examine Funeral **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any nijury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Euperal Dire Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Physician

		For State Registrar		(	State o	f Mary	land /	Depa	ırtmen <i>tificate</i>	t of H	ealth eath	and M	lental Hy	gien/ Reg. N	- (-, 0	10		309	98
-:-:-	/	Decedent's Nam	ne (First, Middle	e, Last)									2. Date of Do	eath		V	3.	Time of Dea	ath
sicia Iedic		Albert		ranci			W	ilso					Januar	·y 2	, -	Year		306 р	М
amin	er	4a. Facility Name (if 101 Morg				•			4b. City, Ch	Town, or .este				4	c. County Kent		1		
eral ctor		5. Social Security N 458-74-7		6. Sex 1 □ <b>X</b> N	И 2 □ F	7. Age ( <i>ln</i> )	rs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	Min.	8. Date of Bi (Month, D Nov. 2	rth ay, Year 1	44	g. Birth Cour Mar	nplace ( intry) y I a i	State or For nd	reign
¥	١	Usual Residence of 10a. State	f Decedent 10b. County			100	City To	wn or Loc	ation								10d In	side City Lir	mite
ified	Director	MD	Kent					erto										Yes 2	
e not	ä	10e. Street and Nur					21000	CILO	10f. Zip	Code				10g. 0	Citizen of \	What Cou		Δ	
nust b	Funeral	101 Morg	nec Rd.	. Apt	. J 2	02			216	520					USA				
any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fui	11. Marital Status 1 ☐ Never Marr	ried 2 🗆 Mar		Was Dece Armed For 1 Yes If Xes, Give	rces?	n U.S.	If	Yes, spec	ify Cuban	, Mexica	an, Puerto	ecify Yes or No Rican, etc.)	-		e - Ameri ck, White,		dian,	
al Exa		3 Widowed			Year or Da	e ites.		1	☐ Yes 2	X No	Specify	y: 			Specify:	Wh	ite		
Nedica	ompleted		15. Decede ecify only highe		completed)		16	(Give k	ent's Usua ind of wor NOT use	k done di		st of worki	ing	16b.	Kind of B	usiness Ir	ndustry		
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event	To Be	17. Father's Name (		,									e (First, Middle	, Maidei	n Surna <b>m</b> e	e)			
natic	_	Charles 19a. Informant's Na			D.:-4)								wsbery						
r trau		Sean Wil:		mp ( <i>ryp</i> e,	rnny		19						Route Numb					n	
othe		20a. Method of Dis	position	• 🗆 •				of Dispos	sition (Name	ne of			Date		Location -				
jury o		1 🗌 Burial 2 4 🗎 Donation	5 Other (S	Specify)	noval from	State C		peak	eCrem	natio	n	1/22	<u> </u>		vens				
any in		21. Signature of Fu	ineral Service I	icensee	/			F 1	Name and ellow 30 Sp	Address s, H	of Facil e1fe Rd.	enbei Ches	n & New	vnam	Fune D 216	era1 620	Hon	ne	
ian/		Immediate Cause ( disease or condition	art failure. List o (Final				. /		r the mode	of dying	, such as		or respiratory a		raf		Appr	roximate val Betweer et and Death	h_
ical iner		resulting in death)		ſ	Due to (	or as a con	sequence	e of):											
100	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	b	Due to (	or as a con	sequence	e of):											
		that initiated event resulting in death)	ts	с	Due to (	or as a con	sequence	e of):					<u> </u>			-+			
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npieted illed in by the lun <b>e</b> ral alrector, page z strould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2  9  Unknown	months?	23c.		Birth 2 🗀 nant at time	Fetal dea		Ectopic p Other (sp							te of deliventh	very Day	Year	
e detac	by Ph	Part II. Other signif	ficant condition	ons contril	buting to de	eath but no	t resulting	in the ur	derlying c	ause give	n in Par	t I.	23e. Did	tobacco	use contr	ribute to t	the cau	se of death'	?
pino	ted												1 🗆	Yes 2	2 🗆 No		bably	4 🗌 Unkn	
e ∠ si	Completed												24a. Was		1 5	Were auto prior to co death?	opsy fin ompleti	dings availa on of cause	able of
or, pag		25. Was case refern	red to medical							06 DI-	an of Da	ath (Chaol	1 Tes	2 4		1 Yes	2 🗆 [	No	
allecto	To Be	examiner?	,	Hos	pital:	Inpatient 2	P ☐ FB/0	Outpatien	3 🗆 DC	Othor		ath (Check	me 5 Res	dence	6 \ Othe	ar /Snacif	5/)		
10 II		27. Manner of Death	h 5 🗌 Pendir		28a. Date		28b.	Time of injury		Bc. Injury work?	at		28d. Describe				у)		
n eur	Certificate:	2 Accident 3 Suicide	Investi	gation	00 81				М	1 🗆 ነ	∕es 2 [								
ed III by		4  Homicide	determ	nined	28e. Place buildir	of Injury - Ang, etc. (Spe	it nome, i ec <i>ify)</i>	farm, stre	et, factory,	office			28f. Location ( City or To			er or Rura	al Route	Number,	
пріетед пії	Medical	(Check 2 only one) 3	Certifying Medical E Certifying	xaminer: Nurse Pi	On the basi	is of examin	ation and	or investi	gation, in n	ny opinior	, death c	occurred at	the time, date	and plac	e, and due	e to the ca	ause(s) a	and manner	stated.
)_ _		29b. Signature and	title of certifier	K	Ro	00 h	n.D.		29c.	License	number	36	/ma.	29d. D	ate signed	Month,	Day, Ye	ear)	
		30. Name and addr	110		n D	e of death (	1 /		int) In A	re	C	Pen L	toom.	m.	1. 2	216	21		
Stat		31. Date filed (Mont		200		egistrar's Si				,	,	- 1 ×	/	,	, ,	2: 05			7
y <b>istra</b> v 7/20			JA	N 25	<u>7010</u>	Den	ned.	J.	A A	A Company									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03099 For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 923 M JAA Medical gility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glen Surper If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Age (In yrs. last birthday) Country)
Washington. Days Month, Day, Year, / 28 / 1947 1 KM 2 - F 217-46-9829 Yrs. **Director** 62 DC Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 X Yes 2 No MD. Anne Arundel Glen Burnie 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 127 Carroll Road 21060 US 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes Yes, Give Baltimore, Maryland 21215-0036 2 🔀 No 1 Yes 2X No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Maintenance Engineer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Eugene Worley Elizabeth Leah Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Freeman / Daughter 127 Carroll Rd., Glen Burnie, 21060 MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/26/2010 4 Donation 5 Other (Specify) Fort Lincoln Brentwood, MD 21. Signature of Funeral Service 22. Name and Address of Facility Fort Lincoln Funeral Home laxcos 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Int 1. Enter the dijeast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure 1 ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical to (or as a conse uence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) exampliner? 1 ☑ Yes 2 ☐ No Other: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Mghth, Day, Year) 28b. Time of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred ☐ Natural ☐ Accident Suicide 5 Pending UNKM fter death. 1 Yes 2 No Investigation within 24 hours after desti To the Funeral Director: completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) to me Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practicians To the basi of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) Deputy

State Registrar 31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edwin Williams 0330 M 2010 January 16, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SALISBURY WICOMICO ATRIA ASSISTED LIVING If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 X M 2 □ F August 13, 1911 DELAWARE 221-24-2799 98 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 No DELAWARE SUSSEX SEAFORD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number AMERICA 127 SOUTH PAULA LYNN DRIVE 19973 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 📉 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AGRICULTURE College (1-4or 5+) Elementary/Secondary (0-12) FARMER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUSIE FRIEDEL LEVIN A. WILLIAMS, SR. 19a. Informant's Name/Relationship (Type. Print) 19p. Mailing Scott Street and Number of Bural Route Alumber City or Town, State, Zip Code) SON KENNETH R. WILLIAMS SEAFORD, DELAWARE 19973 20b. Place of Disposition (Name of ODD FELLLOWS 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) JAN.20,2010 SEAFORD, DELAWARE CEMETERY Service Lice WATSON-YATES FRONT & KING FUNERAL HOME, INC. STREETS SEAFORD, DE. 19973 Part 1. Enter the disease or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Can e (Final disease or condition resulting in death) Amenosuros curorouncular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical

Physician /Medical Examiner

> and as the burial-tra

attending physician for use as the hurial

the

has page 2

certificate

After this

within 24 hours after death To the Funeral Director:

To the Hospital

funeral director,

filled in by

completely

permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

or items 23a or

"natural"

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Director

Funeral

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Completed

Be

traumatic event, the Medical Examinar must be notified at

l be filed within 72 hours after death with the Maryland ntal Hygiene.

Examiner Physician/Medical þ Completed Be Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assist Correct

1 Tes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Mun

132014

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

106 WIII Oud St SOYR Sailes Buy and U804 Mayery moo

Registrar

31. Date filed (Month, Day, Year)

10-00710 Deena D. Wood Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ena D. Wood		State of Maryland / Department 1- For State Registrar  Certificate		lygiene Reg	2010 0310					
Physicia edical Exami		1. Decedent's Name (First, Middle,Last)  DEENA DARLENE DAVIS WOOD		2. Date of Death Month [ January 24,	Day Year 3. Time of Death 1642 hrs					
		Facility Name (if not institution, give street and number)     Memorial Hospital	4b. City, Town, or Location of Death Easton		4c. County of Death Talbot					
Funeral Director			If Under 1 Year If Under 24Hrs Months Days Hours Mir		(MM/DD/YYYY) 9. Birthplace (State or Foreig Country) Maryland					
te Maryland or 28a-f show any fied at once.	ctor	Usual Residence of Decedent  10a. State	Denton	I 10a	10d. Inside City Limits  1 Yes 2 X No					
with the Maryland ns 23a or 28a-f sho be notified at once.	Il Director	9226 New Lane	21629		United States					
death or ite	by Funeral		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:		14. Race - American Indian, Black, White, etc.  Specify: White					
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Completed t	Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of most of working life. DO NOT use ret		6b. Kind of Business/Industry  Own Home					
21215-0036 build be filed within 7. Mental Hygiene, marked other than it event, the Medica	Be Con	17. Father's Name (First, Middle, Last) William J. Davis	18.Mother's Name	(First, Middle, Ma	Davis					
MD 2 d 2 should the and M n 27 is m aumatic	To	Joseph Wood/ Husband 92	ng Address (Street and Number or 1 26 New Lane, De	enton, l	MD 21629					
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Important: If item 27 is nijury or other traumati		1 Bunal 2 X Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify:	Cremation Center 1/2		Cambridge, MD					
Balt permit Depart Impor injury		Polorile CFSP	•		leralsburg, Maryland					
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive atheros  Due to (or as a consequence of):			Between Onset and					
ed nsit	Examiner	Sequentially list conditions, b								
50, te be executed ysician and burial - transit	edical	X UNPENDED AMENDED 23a,PII,27,	perm,E g900 2/19/	10 TT						
b.O. Box 6876( that the death certificate ned by the attending physicate detached for use as the b	ΣI	past 12 months?	Fetal death 3 Ectopic pregna	ncy	23d. Date of delivery Month Day Year					
s, P.O. I	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the  Obesity; Diabetes mellitus	underlying cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 V Unknown					
Vital Records, sysician: The law requirements this certificate has been a director, page 2 should	Completed			24a. Was an autopsy performe						
J of Jing Ph After 1 funeral	To Be	25. Was case referred to medical examiner?  1  Yes 2 No			esidence 6 Other:					
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, str		28f. Location (Stre or Town, State	eet and Number or Rural Route Number, City e)					
o the Ho rithin 24 I o the Fu	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occ one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.								
H 2 H 2	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year) January 25, 2010					
			Penn Street, Baltimore, MD	21201						
Sta Regist	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	20							

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006 10-00722 Eric Wagner

Physician/

**Medical Examiner** 

**Funeral** 

Director

or 28a-f show

Director

Funeral

ã

Completed

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other reamaitie event, the Medical Examiner must be notified at once,

Baltimore, MD 21215-0036

1. For State

10a. State

MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 03102 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Month Day January 24, 2010 2045 hrs WAGNER ERIC 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c County of Death Howard Columbia 5458 Harpers Farm Road Apt. B4 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Foreign Country) Days Months Hours NOV 27, 1960 49 222 46 2157 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1XX Yes 2 No COLUMBIA HOWARD 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 21044 USA 5458 HARPERS FARM RD., APT B4 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 Married 2 X No Yes Yes, Give Year WHITE 1 Yes 2 X No specify. 4 X Divorced Specify 3 Widowed 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ATHLETICS ATHLETIC TRAINER/TEACHER 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARLENE A. SNYDER RICHARD L. WAGNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CON WEST DRIVE, HOCKESSIN, DE 19707 WELLINGTON RICHARD L. WAGNER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, JAN 27. 1 Burial 2 X Cremation 3 Removal from State crematory or other place) FAMILY CREMATION SERVI 2010 WILMINGTON, DE Donation 5 Other Specify 22. Name and Address of Facility
MEALEY FUNERAL HOMES
PO BOX 2866, WILMINGTON, mature of Funeral Service Licensee M00784 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line Death Seizure disorder Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Viral encephalopathy Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23d Date of delivery

**Physician** riviedical xaminer

X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions contri

Examine and tran Physician/Medical attending physician or use as the burial Š Be Completed ၣ within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

D	ue to (or as a co	onsequ	uence of):						
]	AMENDED	PΙ	line	a-b,	27,	permE	g900	2/5/10	TT
	23c. If yes, out								
	1 Live birth	h		2 F	etal death	3 E	ctopic preg	nancy	- 1

Jos, sarasina a. p 3	-,					
Live birth	2 Fetal death	3 Ectopic pregnancy		Month	Day	Year
Pregnant at time of death	5 Other (Specify)			ì		
Unknown						
buting to death but not resul-	ting in the underlying cau	ise given in Part I.	23e. Did toba	cco use contribu	te to the caus	e of death?

							1 [	Yes 2 ✓	No 3 Probably	4 Unknown	
								a Was an autopsy performed? Yes 2 No	24b. Were autops prior to comp death? 1  Yes	y findings available letion of cause of 2 No	
25. Was case referred to medical					26.Place	of Death (Check	only one)	)			
examiner? 1 ✓ Yes	2 No	Hospit	al: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nursin	ng Home	5 Residence	ce 6 🗹 Other: Sce	ne	
27. Manner of Death	1	12	28a. Date of Injury	28b. Time of Injury	28c. Inju	ry at Work?	28d. De	scribe how injury	occurred		
1 X Natural	5 Pending		(Month, Day,Year)		1	Yes 2 No					
2 Accident	Investiga				-		00/ 1		N D D	North Alberta Cit	
3 Suicide 6 Could not be			28e. Place of Injury - At home, farm, street, factory, office building, etc.					28f. Location (Street and Number or Rural Route Number, City or Town, State)			

3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, street, farm, street, street, street, street, str	ctory, office building, etc.	28f. Location (Street and Number of Rural Route Num or Town, State)
29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred a money one)  2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.		
29b Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  January 26, 2010

0 6	100	1.2	10-	- V	-	
30. Name	and address	s of person	who comple	eted cause	of death	(Item 23a

Assistant Medical Examiner Victor Weedn MD JD

OCME

111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 01 SEYMOUR L. YANOFSKI 2010 9:40 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CAROLINE HOME FOR HOSPICE DENTON CAROLINE If Under 1 Year If Under 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Min. Hours Country) Director Yrs 130-03-5828 89 10-16-1920 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Tes 2 No MD TALBOT WITTMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 8473 TILGHMAN ISLAND ROAD 21676 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give 10 Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates. 1945 3 Divorced 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than 2 should be filed within 7 hand Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 MAINTENANCE ENGINEER LIGHT/POWER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည SAMUEL YANOFSKI ALICE SOLOMAN and 2 should b Health and Me tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8473 TILCHMAN ISLAND ROAD, WITTMAN, MD 21676 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t WIFE SHETLA YANOFSKI Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place OXFORD, MARYLAND D1 - 19 - 2010OXFORD CEMETERY 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service Licensee Part 1. Enter the deease, or complications that shock, or heart failure. List only one cause on earth or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Physiciani Medical Examiner resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death ed by the 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 1 Tes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law has autopsy perform certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 XNo Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6X Other (Specify) **hospice** 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 🗌 Yes 2 🗌 No Accident Investigation 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

State Regist<u>rar</u>

IVA RS In Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 7:46 AM Mendez A. Yearwood 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges Prince Georges Hospital Hyattsville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1 X M 2 □ F West Indies 87 **Director** 12/23/1922 220-62-9808 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show r items 23a or 28a-f shov iner must be notified at 11 Yes 2 No Director Colmar Manor Prince Georges MD. 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20722 US 4206 Lawrence Street Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: Black other than "natural", or rent, the Medical Exam þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ?7 is marked c traumatic eve Augustus Yearwood Catherine Trimm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any Injury or other trau 4206 Lawrence St., Colmar Manor, MD. Florence Jackson / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 1/21/2010 | Brentwood, MD. 21. Signature of Fune Se A Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Tances 3401 Bladensburg Rd., Brentwood, MD. 23a Part 1. Enter the die se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Diabetes Mellitus Due to (or as a consequence of): Box 68760 Physician/Medical Renal Failure attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☑ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s this certificate 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: After this or funeral dire 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pendina 1 □Yes 2 □ No neral Director: A investigation death. 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Funel

completely file (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific Unon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wade Brennom, M.D 3001 Hospital Drive Cheverly, MD. 20785 (Month, Day, Year) State JAN 2 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,29 of Maryland Chenaring poor 120 10 272 Mortal Hygiene 1 - For State Registrar Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not in Location of Death Examiner 4b, City, Town 4c. County of Death Medica MOYE DY Age (In vrs. last birthday 8. Date of Birth
(Month, Day, Year)
4-1-1950 9. Birthplace (State or Foreign **Funeral** 1 🔀M 2 🗆 F Months Hours Min. 50 Director 087-40-6854 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5456 Narcissus Avenue 21215 S TT Α 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Yes 2 ☐ No If Yes, Give ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 💢 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) grade Mc Vet Center 12th 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u> Gladys Boynes</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt B 1400 Strawflower Road Tahesha Boynes-daughter Essex, Md 21221 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place. Greenmount 1-15-2010 Balto, MD March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility B 1101 E. north Avenue Balto, MD 21202 9 ans 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death e ps 15 Physician disease or condition resulting in death) Medical Due to or as a consequence of Examiner mon4 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to fir as consequence of the burial-transit Esophagea

Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMIN and that initiated events resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Yes 2 No t signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 🛣 No 28d. Describe how injury occurred **Esophageal injury s/p** Natural Unknowa 5 Pending 12/08/2009 2 X Accident Investigation mediastinoscopy. 6 Could not be 3 L Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 10 N. Greene Street determined **Hospital** Baltimore, MD Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certific 29c. License number P24512 29d. Date signed (Month. Day, Year) 1.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip 31. Date filed (Month, Day, Year) 32, Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20h per per per 16 110 and Mental Hygiene For amend item 10e, 19b per inf 9900 2-23-10 vt.

Registrar

Certificate of Death

Reg. No. Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 06 PM 12GINIA FERZUAL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAUMOR ENTER na HOPKINS BAYVIEW MEDICAL . Social Security Number Year If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 DM 2XX Months Days Hours Min. (Month, Day, Year) -15-1944 Country) 215-40-4322 **Director** 66 N.C Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 🏋 Yes 2 □ No MD na Baltimore 10e. Street and Number
Marx
4109 10f. Zip Code 10g. Citizen of What Country? Funeral - Avenue 21206 U S A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Was Deceden \_\_\_\_ Armed Forces? 1 ☐ Yes 2 💢 No Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Packer Solo Cup Co. 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isiah Moore Rosetta Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4109 Marx Avenue Balto, MD 21206 19a. Informant's Name/Relationship (Type, Print) James Barnes-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 15<sup>Date</sup> 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Bemoval from State 4 Donation 5 Other (Specify) Greenmount 2-<del>9</del> 2010 5 Other (Specify Balto, MD 21. Signature of Femeral Service March East F/H 22. Name and Address of Facility 1101 E. North Avenue Balto, 21206 MD 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ DIOPATHIC PULMONTRY Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to or as a consequence of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ate has been signed by the atter page 2 should be detached for i in the past 12 months? Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 2 No 2 🗌 No 1 🗀 Yes and after death.

ral Director: After this cerum.

I in by the funeral director; pr Yes Be B 25. Was case referred to medical 26. Place of Death (Check only one) examine ? Other: 2 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination alread investigation, it my opinion, occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 0028684 FEGUAN 5, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD ms 4940 EASTERN QUENUE BALTIMORE, BESSMAN 31. Date filed (Month, Day, Year) State FEB 0 5 2010 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Marylan		artment of H		and M	ental Hy	giene	010	00107	
			1 - State Certificate of Death								Reg. No.	<u>'UIU</u>	03101	
Dhy	sicia		1. Decedent's Name (First, Middle,							<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of Death	
	edic		MARY BLUE	1						JANUARY	29	2010	14:35 PM	
Exa	mine	er	4a. Facility Name (If not institution,	T=2	4b. City, Town, or		of Death		4c. C	ounty of Deat	ר			
ar i			JOHNS HOPKINS BAY				If Under 1 Year	If Under	24 Hrs 1	0 D-tf Bi-	11-	N/A		
Fune			5. Social Security Number 220–18–9284	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 84	yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Da	y, <i>Year)</i> 0,192	l Co.	hplace (State or Foreign untry)	
Direc	tor	-	Usual Residence of Decedent		04					Oct. 2	0,192	. Ina	ryland	
'land		ŀ	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits	
Mar)	INC	호	MD	Baltimor	e		Dunda	alk					1 ∐Yes 2⊠ No	
h the	9	ie	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Co	untry?	
h wit	121	<u>a</u>	3480 Dunhaver	Road				212	22		Uni	ted St	ates	
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show	Ē	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U.	S. 13.\	Was Decedent of H	ispanic Or an. Mexicar	igin? (Spe	cify Yes or No Rican, etc.)	- 14	I. Race - Ame Black, White		
after or it		by Fu	1 Never Married 2 Marrie		2 ☑ No	i	1 □Yes 2½ No	Specify:		, , , ,				
Z I 3-UUSO hin 72 hours aff e. an "natural", or	EX		3₺ Widowed 4 Divorced	Year or	Dates:							WII	ite	
72	office of	ee	15. Decedent's (Specify only highest	grade completed	)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	t of workin	ng	160. Kind	o. Kind of Business/Industry		
withii ene.	2	Completed	Elementary/Secondary (0-12)	College 2 Yea	(1-4or 5+)		Owner tography	″ Stud	io		Pho	togran	hy Studio	
filed Hygi	ent, n		17. Father's Name (First, Middle, L.			1110	cography			(First, Middle,			ily bedate	
	ic ev	To Be	Matthew Zahner					Jo	sephi	ne Hur	ka			
laryland ZIZ 2 should be filed within and Mental Hygiene. Is marked other than	nmat	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailing Address (Street and Number or Rural				ral Route Number, City or Town, State, Zip Code)				
Mal and 2 sh saith and 27 Is n	er tra		Daniel A. Block	ı, Jr.	(Son)	56 S	. Dundall	k Ave	nue	Dunda1	k, Ma	ryland	21222	
of Hea	6		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place	e)	D	ate	20c. Loca	ation - City or	Town, State	
altimo	o Li		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				of Faith		2/2/	2010	Bal	timore	, Maryland	
	any inj		21. Signature of Funeral Service Li	censee		$\frac{22}{D}$	2. Name and Addre uda—Ruck	ss of Facili Fune	ral H	lome of	Dund	alk, I	nc.	
<b>1</b> 88 <b>a</b>	E 0		- Souther	<u> </u>		7	922 Wise	Mve.	Dun	dalk, l	Mary1	and 2	1222	
	и		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Physic	_	1	Immediate Cause (Final disease or condition _ a STROKE WITH HEMORRHAGIC CONVERSION										4 DAYS	
/Medi Exami	-		resulting in death)		o (or as a conseq	,								
	•	_	Sequentially list conditions, if any, leading to furnished to cause. Enter Underlying Cause (Disease or injury									NEDENN		
ted i:	isi.	nin												
execu	al-tra	Examiner	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):								
icate be executed physician and	uno e	dical												
	as I	ledi					~~							
ath cer	asn	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregna	ancy	Tectonic pregnanc	V			23	3d. Date of del		
The law requires that the death certificate has been signed by the attending	o pa	hysician/Me	2   Neas december pregnant     Live birth   2   Fetal death   3   Ectopic pregnancy									Month Day Year		
at the	eracu	Phy	9 Unknown			Was to the same		in Deat		22a Did t	obooo uo	o contributo to	the cause of death?	
JS, res th	De di		Part II. Other significant condition					en in Part i		23e. Dia 1		/	robably 4 Unknown	
requi		sted	HYPERTENSION	, PULL	ISNARY	EMBO	12230							
Hecords, he law requires t e has been signe	S C	Completed by								24a, Was autoj		24b. Were au prior to death?	topsy findings available completion of cause of	
T. Th	r, pag									1 □ Yes	2 No	1 ☐ Yes	2 🗆 No	
VITAI sician: T certificat	OLD	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	7		ot a Door Oth	or:		(Check only o				
P Py P	B B	٦	27. Manger of Death	28a. Dat	e of Injury	ER/Outpatier 28b. Time of	" 3 DOY	4 🗆 14		ne 5 Resi	_		cify)	
on ding	Inue	įį	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		nth, Day, Year)	Injury	f 28c. Injur Worl	ќ? Yes 2□						
Attending at death.	oy iii	ertification:	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	e of Injury - At he	ome, farm, str	eet, factory, office		2	28f. Location (	Street and	Number or Ru	ural Route Number,	
s afte		Cert	4 Homicide determin	Dull	ding, etc. (Specif	(y)				City or To	wn, State)			
ospit hour	)   		29a. Certifier 1 Certifying	Physician: To the	ne best of my kno	owledge, deat	h occurred at the ti	me, date a	nd place, a	and due to the	cause(s) a	and manner a	s stated.	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has	npiett	Medical	one)	and ma	nner stated.									
마 로 로	8	2	29b. Signature and title of certifier	. 17			29c. Licens	e number				signed (Mont		
			Benjami								~,,,,,,,		1,2010	
6v			30. Name and address of person w		use of death (Iter		Print)	LTIME	REIL	1) 213	124			
<u> </u>	Stat	e	31. Date filed (Month, Day, Year)	32.	Redstax's Signa	ature					•			
Reg	gistra		FEB 05	2010	ener.	1.	Same							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Deat 2. Date of Death 1. Decedent's Name (First, Middle, Last) February Day 3. Physician/ 2010 5:20 p M Virginia Braun Margaret Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Middle River 921 Cold Bottom Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 🗆 M 2 🙀 F JW9nth, Dgy, Year) 931 MaryTand 216-28-1310 78 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Middle River MD Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral U.S.A. 921 Cold Bottom Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: Yes, Give Specify: White Be Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Acme Markets Meat Wrapper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mae Otto Henry Clark Lacy Lark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 921 Cold Bottom Rd., Middle River, MD Honey Manzari-daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley 2/10/10 Timonium, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury STAGE been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 W No

9 Unknown Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed Yes 2 1 TYes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide n 24 hours after death.

e Funeral Director: A sleted filled in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D22652 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) OI LOCHRAVEN

SURRAMANIAN SRINIVAS 5601 LOCHRAVEN SUBRAMANIAN

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 28, Maggie Janine Brown January 2010 11:34 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 5139 Celestial Way Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Dec 12, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** . 1939 Hours Months Days 1 M 2 XX 150-32-0482 West Virginia 70 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, If a Medical Examiner must be notified at sonce. MD 1 ☐Yes 2 XNo Director Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5139 Celestial Way 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 | No If Yes, Given X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 ▼ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Chemist Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Louise Fields Samuel Arthur Earle ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5139 Celestial Way Columbia, Maryland 21044 Nesbitt D. Brown (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Gardens 2/1/10 Clarksville, MD Gary 7250 Name and Address of Facility L. Kaufman Funeral Home at MMP, Inc. 250 Washington Blvd. Elkridge, Maryland 21075 21. Signar re of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Entry the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Immediate Cause (Final **Physician** HONTH disease or condition resulting in death) ASTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 □Yes 2 W No 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA Certification: To 27. Manner of Death 1 Dinatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 123683 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MU) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Petrent Known as Mark Brewing For

			State of Maryland / Department of Health and Mental Hygiene  1 - State Amend Item 21 per fh,g900,02/05/2010dhb Registrar Registrar Registrar Registrar Registrar Registrar	n							
	Physicia	n/	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day 10- Year  3. Time of Death								
Medical Examiner		er	2. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Ac. County of Death  Raltmore City								
	Funeral Director		5. Social Security Number 216-02-2633   1 🔀 M 2 $\square$ F   7. Age (in yrs. last birthday) 31   Yrs.   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (worth, Day, Year) 9, Birthplace (State or Foreign Country) 4   Marry 1 and   9. Birthplace (State or Foreign Country) 4	n							
•	aryland ia-f show ified at	ector	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 11d. Yes 2 \( \text{N} \)	- 1							
J	vith the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 4013 Aragon Avenue 10f. Zip Code 21215 10g. Citizen of What Country? USA	$\neg$							
980	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show i, the Medical Examiner must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1								
Baltimore, Maryland 21215-0036	within 7; giene. er than the Mc	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Disable  16b. Kind of Business Industry  Disable								
land	를 <del>할 할</del>	To Be	17. Father's Name (First, Middle, Last)  Michael Brewington  18. Mother's Name (First, Middle, Maiden Surname)  Veronica Phillips								
Mary	2 shou th and th sm traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  4013 Aragon Ave., Baltimore, MD 21215								
more,	0		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metro Crematory  20c. Location - City or Town, State  01/21/2010  Baltimore, MD								
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee  Brian Howell, Sr per DVR  22. Name and Address of Facility Howell Funeral Home 4600 Liberty Heights Ave., Baltimore, MD 21207								
	be ey siciar burit	cal	/Medi	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):							
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the			ysician/Med	ysician/Med	ysician/Med	ysician/Mec	ysician/Mec	ysician/Med	ysician/Mec	ıysician/Mec
ls, P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1	'n							
Division of Vital Records,	ysician: The law req is certificate has bee director, page 2 shou	e Completed by	Diabetes  24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No  25. Was case referred to medical  24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No  25. Was case referred to medical								
f Vita	Physicie this cert ral direct	: To Be	examiner?  1								
ion o	tending death. tor: After the funer	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident towestigation M 1 ☐ Yes 2 ☐ No								
Divis	ital or Al urs after or ral Direc lled in by	al Ceri	4 Homicide determined determined determined building, etc. (Specify)  286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)  287. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After this completed filled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ted.							
	To with		29b. Signature and title of certifier  Park  29c. License number  29d. Date signed (Month, Day, Year)  FEB 3, 2010								
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kijchen Navia, SINAI HOSPITAL								
	Stat Registra	.0	31. Date filed (Month, Day, Year)  32. Registrar's Signature								
	MH 17 Bey 7/20		LU U O ZUIU CENONE A. Marie								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Month Year 11:30 PM January 28, 2010 Christine Elizabeth Blanks 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 50 Dec 02, 1959 Washington 217-78-7627 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Joppa Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 3315 A Clayton Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor Weber Eric Eberhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Blanks /Daughter 1 Tadmore Ct. 303 Parkville, MD 21234 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Feb 0.6 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardial 4 days disease or condition resulting in death) Due to (or as a consequence of): days Myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury UNKNOWY chephal HNUXIL that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? reivil 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Me Yes 2 □ No 1 ➡ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural

Christine M80048610 P.O. Box 68760, ≪ Division of Vital Records, To the Hospital or Attending PhysIclan: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Blanks

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

P

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it s Medical Examination must be mailfud at

and Mental Hygiene.

Department of Health a Important: If Item 27 Is any Injury or other training.

**Physician** 

/Medical

Examiner

cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit

Physician/Medical

δ

Completed

Be

Certification: To

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

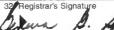
29b. Signature and title of certifier MO D0065421

and manner stated.

01,29,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chisaplace Dave, But Air, MD 31014 T-1Ster, MD

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 2010 Daniel G. Blake, Jr. 11:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12218 Benson Branch Rd. Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 4/30/1930 Days 1 St M 2 D F Min. Director 79 MD 218-26-4674 Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f shoo other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 XNo MD Ellicott City Howard 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 12218 Benson Branch Rd. 21042 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Daniel G. Blake, Sr. Mary Elizabeth Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellean A. Blake / Wife 12218 Benson Branch Rd., Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Park 2/9/2010 Glen Burnie, MD 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature of Junetal Service Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or at a conseque attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: **Division of Vital** 25. Was case referred to med 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) thin 24 hours after death.

the Funeral Director: After thi
mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: to the best of my providedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier ۵ 028246 of death (Item 232) (Type, Print) 10298-B Baltimore National 30. Name and address of person who completed Ellicott City, MD 21042 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2010								
Physician/	1. Decedent's Name (First, Mid	dle,Last) RaShod	Covin	met an Mor	e of Death oth Da	v Year	3. Time of Death 1120 hrs		
Medical Examiner	Darius  4a. Facility Name (if not institut			or Location of Death	uary 9, 20	10 4c. County of Death	1120 1115		
	1608 N. Calvert Stre	_	Baltimore			,			
Funeral	5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday) If Under 1 Your Months Do	ear If Under 24Hrs. 8. Da	ate of Birth (M	(M/DD/YYYY) 9. Birth Cour	place (State or Foreign		
Director	216-51-1981	1X M 2 F 1	2 Yrs. World's D.	ays Hours Will. 12	2 02	97	MD		
any	Usual Residence of Decedent 10a. State 10b. County	/ 10c.	City, Town or Location				10d. Inside City Limits		
) <u> </u>	MD i	NA	Baltimore				1X Yes 2 No		
Maryland 28a-f show 1 at once	10e. Street and Number	<u> </u>	10f. Zip Code	1	10g. (	Citizen of What Count	ry?		
15-0036 Ified within 72 hours after death with the Maryland I Hygiene. 4 other than "natural", or items 23s or 28s-f shoot, the Medical Examiner must be notified at once. B Completed by Funeral Director		Calvert Stree		21212		U.S.A			
ath wit items 2 ist be n	11. Marital Status 1 X Never Married 2	12. Was Decedent Ever	If Yes, specify Cub	Hispanic Origin? ( Specify Y an, Mexican, Puerto Rican,		14. Race - America White, etc.	an Indian, Black,		
fter de I'', or i IET. MU		1 Yes 2 X N	1 Yes 2 X	No specify:		Specify: B	lack		
136 hin 72 hours afte e. than "natural", edical Examiner 1pleted by		ecify only highest grade complete	d) 16a. Decedent's Usual Occup during most of working li		ne 16t	b. Kind of Business/Inc	dustry		
5-0036 ed within 72 hour objective. Objective. the Medical Exam Completed	Elementary/Secondary (0-12 7th grade	College (1-4 or 5+)	Student	,		School	1		
5-00; led with Hygiene other ti	17. Father's Name (First, Middl		364455	18.Mother's Name (First,	Middle, Maid				
21215 uld be file Mental H marked o c event, tt	Robert Cov:			Shawnters					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mernal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumaric event, the Medical Examiner. To Be Completed by I	19a. Informant's Name/Relation	ship (Type, Print) Brooks-Mothe	19b. Mailing Address (Str	reet and Number or Rural Ro Calvert St	reet	. Baltime	ore, Md		
mand 2:	20a. Method of Disposition		Ob. Place of Disposition (Name of		20	c. Location - City or T	1 2 1 2 own, State		
Baltimore, permit. Pages I ar Department of He Important: If ite	***	on 3 Removal from State	crematory or other place)  Mt. Zion	1/15/		Baltimor			
altin mit. P. partme portan	4 Donation 5 Other 3	Specify:		H West ash Ave, Ba					
	omala	. C. many	1				Approximate Interval		
Physician	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Examiner	or condition resulting in death)	Due to (or as a consequent	ons of heterotax	ia			Death		
	Sequentially list conditions,	b							
nine	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated		ce or):						
ted Insit	events resulting in death) Last	Due to (or as a consequent	ce of):				· <del>-</del>		
and tra	X UNPENDED	d AMENDED 23 2 27	,permE, g900 2/	22/10 TT			_		
760, cate be exu physician he burial -	IF FEMALE:	23c. If yes, outcome of p			1:	23d. Date of delivery			
Sox 6876( death certificate te attending phy. I for use as the b	23b. Was decedent pregnant in past 12 months?	the 1 Live birth 4 Pregnant at time of	Z J rolar doal.	Ectopic pregnancy		Month Da	y Year		
). Box the death by the atte	1 Yes 2 No 9 U	nknown g Unknown	Uther (Specify)				\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u completed by Physic	Part II. Other significant cond	itions contributing to death but r	not resulting in the underlying cause	e given in Part I. 23		co use contribute to the			
cords, P.O. law requires that the has been signed be 2 should be detail in profeed by 3					a. Was an	7,2 2 2 2 2 2 2 2 2 2 2	psy findings available		
Records,  The law require: ficate has been signage 2 should be Completed	-				autopsy performed	prior to co	mpletion of cause of		
	25. Was case referred to medic		26 Pla	ace of Death (Check only on		No 1 Yes	2 No		
Vital   ysician: his certif director, o Be (	examiner?	Hospital: 1 Inpatient 2		Other: Nursing Home		idence 6 🗸 Other:	Scene		
of Vi ing Physi After this uneral dir	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Ir	njury at Work? 28d. D	escribe how	injury occurred			
ion frendi death. ttor: / the fi		nding estigation		Yes 2 No					
Division of Vital Records, P.O.  To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Functional Director. After this certificate has been signed by completely filled in by the functal director, page 2 should be deadledical Certification: To Be Completed by F	det	uld not be ermined (Specify)	At home, farm, street, factory, office		cation (Stree Town, State)	et and Number or Rura )	Route Number, City		
C Spin Pour	4 Homicide	(opec.,)	wledge, death occurred at the time,	date and place, and due to	the cause(s)	and manner as stated	l.		
To the Hos within 24 h To the Fur completely	one) 2 Medical Ex	on, death occurred at the tir	ne, date and	place, and due to the	cause(s)				
A L 3 L 3	29b. Signature and title of certif	and manner stated.		nse number		d. Date signed (Mont	h, Day, Year)		
	alun	what		C.M.E.	Ja	anuary 10, 2010			
	<ol> <li>Name and address of person</li> <li>Zabiullah Ali, M.D.</li> </ol>	on who completed cause of beath ( Assistant Medical Exami		altimore, MD 21201					
State	31. Date filed (Month, Day, Year	) 32. Registrar's Sig							
Registrar	JAN 1 4 201	O Serve A.	parker			00115			
DHMH 17 Rev 1/2001 OCME 2006			ORIGINAL			OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 tems 20b,c per fh g901 3-9-10 vt
State of Maryland / Department of Health and Mental Hygiene / | | 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 4a. Facility Name (If not institution, give street and number) 147A M 2010 /Medical 4c. County of Death Examiner N/A The Johns Hopkins Hospital **Baltimore City** 9. Birthplace (State or Foreign Country)
Greece Social Security Number . Age (In yrs. last birthday) **Funeral** 217-74-8541 1 □ M 2X F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If iten 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Numbe 5805 Elkins Street 21061 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify. þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be and Mental Sophia Nikitidis Panagiotis Pakaki ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Chrysovergis - Son 5805 Elkins Street, Glen Burnie, MD 21061 If item 27 i Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of Note in Corp. Dameon death is place) Date 20c. Location - City or Town, State permit. Pages 1
Department of It
Important: If ite
any injury or ot ☐ Burial 2 ☐ Cremation 3 XRemoval from State Laval Quebec, Canada 2-<del>10-</del>2010 4 ☐ Donation 5 ☐ Other (Specify) Outremont, Signatura of Funeral Sami 22. Name and Address of Facility Ambrose Funeral Home, Inc. Ø 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of): **Examiner** registant staphylococcu aureus saque mally list our office if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day detached for Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the þ The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 🗌 No Yes certificate 25. Was case referred to medical Physician: 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Hospital or Attending After **Jeral Director**: Af 1 Yes 2 No after death. 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 February 3,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 200 31. Date filed (Month. State FEB 0 5 2010 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 23aPt1, 25 per me, g900,02/04/2010dhb Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARLES 6.20 AM DYER Ö١ JANUAR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death JOHNSHOPKINS BAYVIEW HEDICA BALTIHORE NTER 8. Date of Birth

(Month, Day, Year)

January 18,1925 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 **k** M 2 □ F Days Washington, DC 220-16-4598 Director 84 Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 Tes 2 X No Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21044 10533 Morning Wind Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian þ 1 Never Married 2 🔀 Married 1 X Yes 2 If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: 3 Divorced 4 Divorced Year or Dates. Army White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Physicist Federal Government Be other traumatic event, filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Charles Howard Dyer Nettie Cooksey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Dver (Wife) 10533 Morning Wind Lane Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or o 1 Durial 2 🔀 Cremation 3 D Removal from State Atlantic Crematory 1-4-2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Witzke Funeral Homes, 5555 Twin KNOLLs Road Inc. Columbia, Maryland 21045 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 DAYS Immediate Cause (Final CEREPRAL HEMORPHAGE Physician/ INTRA disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Amyloid Angiopathy 5 years Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit ON APPROVED BY MEDICAL EXAMINER or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of). resulting in death) Last CERTIFICATI Physician/Medical IF FEMALE be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed' death? 1 ☐ Yes 2 ☐ No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 Tes 2 🗌 No within 24 hours after death To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RECTOENT 000

State Registrar

**2**6

940 EASTERN AVENUE, BAUTZHORE MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G900 2/05/2010 JH

Amend 20b, per Fh g900 2/17/10 TT

Certificate of Death

Reg. No 2 | 1 For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O 2 **Physician** 2010 Betty Davis 01 6:45p.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Elizabeth's Nursing Home
Social Security Number 6. Sex 7. Age (In yrs. last bir Baltimore If Under 24 Hrs. Hours Min. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🗆 F Months 194-26-0602 **7**8 Director MS Usual Residence of Decedent with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner rust be notified at Director 1 ☐ Yes 2√ No MD Baltimore Essex 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21221 U.S.A. death v Funeral 347 Hopkins Landing Driving 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. à Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ementary/Secondary (0-12) College (1-4or 5+) Homemaker House 10th grade permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other I any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morgan Williams Nancy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 347 Hopkins Landing Driving, Essex, MD 21221 Rufus Davis-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2/<del>10</del>/2010 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State On-Site 2/8/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md 21. Signature - Funeral Service Licenses 22. Name and Address of Facility

March F/H West
4300 Wabash Ave, Baltimore, Md 21215 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** demento disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit it To and Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Steoporosis 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☑ No 2 🗆 No 1 ☐Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation in 24 hours after death.

In Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☑ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRED R111615 2/2/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BensonAve. Goldsborough State Registrar

DHMH 17 Rev 1/2001

10-00818 Kevin Davis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Revin Davis	1- For State Registrar	tate of Maryland / D	Certificate of D		Re	eg. No. 2010	03117
Physician/ Wedical Examine	Decedent's Name (First, Midd Kevin	<sub>lle,Last)</sub> Bernaro	ď	Davis	2. Date of Dea Month January 2	Day Year	3. Time of Death 1742 hrs
	4a. Facility Name (if not institution University Hospital		4b.	City, Town, or Location of	<del></del>	4c. County of Death	)
Funeral	5. Social Security Number	6. Sex 7. Age (In	n yrs. last birthday) I	Under 1 Year If Under		th(MM/DD/YYYY) 9. Bir Foreig	
Director	218-94-5667 Usual Residence of Decedent	1KM 2F 3	Yrs.	Months Days Hours			untry) MD
w any	10a. State 10b. County	NA 100	c. City, Town or Location	oro			10d. Inside City Limits
the Maryland a or 28s-f show tiffed at once.		IVA		Of Zip Code	1	0g. Citizen of What Cour	1 XYes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once, er all Director	307 North Po	ppleton Stre	eet	21201		U.S.A	•
5-0036 led within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	11. Marital Status 1 X Never Married 2 M	larried 12. Was Decedent Ever Armed Forces? 1 Yes 2 X	If Yes,	ecedent of Hispanic Orig specify Cuban, Mexican,		White, etc.	can Indian, Black,
s after d		vorced If Yes, Give Year or Dates:	1 Ye	s 2X No specify:	in a female dans	ореспу.	lack
5 72 hour na "natu sal Exar leted	Elementary/Secondary (0-12)		during most	Jsual Occupation (Give I of working life. DO NOT		16b. Kind of Business/I	
5-0036 lide within 72 hours Hygiene. I other than "natur the Medical Exami Completed k	11th grade 17. Father's Name (First, Middle	Last)	Un	employed 18.Mother	s Name (First, Middle, M	Unempl Maiden Surname)	oyed
	Jerry Davis				oria Jeff		
AD 2 sho 27 is mati	19a. Informant's Name/Relations Victoria Jef	, , , , ,	1.3			nber, City or Town, State	
ore, s I and of Heal	20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal from State	20b. Place of Disposition crematory or other p	(Name of cemetery, place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages La Department of He Important: If ite	4 Other S 21. Sign to e of Funeral Service		On-Site		2/5/10	Baltimor	
	23a. Part I. Enter the disease, or	13- Hete				imore, Md	
Physician Medical	lailure. List only one cause	ardiac or respiratory and	est, shock, or fleart	Approximate Interval Between Onset and Death			
Examiner	or condition resulting in death)	Due to (or as a conseque	ence of):				
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	ence of):				
ted 1 ansit Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
50, tte be executed rysician and burial - transit	UNPENDED	AMENDED					
8760 tificate ing phys as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	f pregnancy 2 Fetal o	eath 3 Ectopic	pregnancy	23d. Date of delivery Month	ay Year
). Box 68760, the death certificate be executed the afterding physician and ched for use as the burial - transi. Physician/Medical E)		4 Pregnant at time known 9 Unknown	e of death 5 Other	(Specify)			
Records, P.O. Box The law requires that the death cate has been signed by the arte page 2 should be detached for the completed by Physic	Part II. Other significant condit	tions contributing to death but	t not resulting in the unde	rlying cause given in Par		bacco use contribute to	
cords, F aw requires has been sig 2 should be	-					an 24b. Were aut	topsy findings available ompletion of cause of
of Vital Records, ag Physician: The law requires.  The this certificate has been signered director, page 2 should be a: To Be Completed					autop: perfor  1 ✓ Yes 2	med? death?	· _
Vital Rec ysician: The his certificate director, page o Be Con	25. Was case referred to medica examiner?		2 🗸 ER/Outpatient 3	26.Place of Death (	Check only one)  Nursing Home 5	Residence 6 Other	·
n of \ding Phy t. After th funeral on: To	1 V Yes 2 No 27. Manner of Death 1 Natural 5 Death	28a. Date of Injury (Month Day Year)	28b. Time of Injury		28d. Describe h	now injury occurred	
Division o spital or Attending tours after death.  Theral Director: Affilled in by the fune	2 Accident Inve	stigation	- At home, farm, street, fa	1 Yes 2 ✓ ctory, office building, etc	c. 28f. Location (S	Street and Number or Run	al Route Number, City
Divolusian oppital opposition affilied in Certification	4 V Homicide dete	rmined (Specify) Local				V. Fayette Street, Balt	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be C	(Check only	hysician: To the best of my kno miner:On the basis of examina and manner stated.					
T × T × Z	29b. Signature and title of certific		<del>-</del>	29c License number O.C.M.E.		29d. Date signed (Mon	
	30. Name and address of person	who completed cause of death	(Item 23a)	J.O.IVI.L.		Junuary 29, 2010	
State	Melissa Brassell, MD	Assistant Medical Ex		Street, Baltimore	, MD 21201		
State Registrar		Deneva B.	ignatur				

Amend 4c, per MD G900 2/5/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 205 LANITA, DUNN JANUART 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death n/a UNZVERSITY OF MARTLAND MEDICAL CENTER BALTZMORE 8. Date of Birth (Month, Day, Year June 25, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 DM 2 5 F Hours Director 214-26-3105 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Harford Maryland Aberdeen 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 USA 405 Dawn Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates. permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Samuel Walter Ethel May Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Dawn Court, Aberdeen, Maryland 21001 Calvin L. Dunn / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Bel Air Memorial Gdn 2-1-10 Bel Air, Maryland Thurs of Funeral Lidensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INTRACRANTAL HEMORRHAGE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HTPERTENSZUE EMERGENC Sequentially list conditions, Examine Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed + TPERTIENSION the attending physician and the for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown has been signed by le 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 24 hours after death.

Funeral Director: After this certificate I 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basic of examination and/or investigation in the cause of examination and/or investigation. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, gearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ite Zhene January 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE STREET BAL TZMORE, State Registrar

10-00857 Joey Dehaven

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joey Dehaven	1	- For State	Sta	ate of Maryla		rtment of <i>tificate of</i>		nd Men	tal Hygiene		2010	0 0211
Physician		tegistrar 1. Decedent's Nam	ne (First, Middle	e,Last)	Cert	incate of	Death		2. Date of De			3. Time of Death
Medical Examine		Joey Way	ne DeHa	even Jr.					Month January			0707 hrs
	ľ	4a. Facility Name ( Harford Me			nber)	4	b. City, Town, o Havre de C		of Death		c. County of Death Harford	1
Funeral									r 24Hrs. 8. Date of B	irth (MM		thplace (State or
Director	Ļ	214-98-7		1 M 2 F	29	Yrs.	Months Day	ys Hours	Min. Nov.	19,	1980 Co	untryMaryland
w any	Ī	10a. State	10b. County			Town or Location						10d. Inside City Limits 1 X Yes 2 No
ryland tryland tronce	3 -	Maryland  Oe. Street and Nu		ford	A	oerdeen	10f. Zip Code		-	10a. Cit	izen of What Cour	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		15 Lewis	Drive				2100	1		US		
r death with , or items 23	1000	1. Marital Status  1. Never Marri	ed 2 X Ma		dent Ever in U.S ces? 2 X No				in? ( Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ameri White, etc.	can Indian, Black,
s after c		3 Widowed	]	rced If Yes, Give Year or Dates:			Yes 2 X No				Specify: Whi	
2 hours "natur	<u> </u>	15. Decedent's Ed		fy only highest grade College (1-			's Usual Occupa st of working life		kind of work done use retired)	16b.	Kind of Business/I	ndustry
5-0036 ed within 72 hour lygiene. to ther than "natu he Medical Exan		12	, , , , ,		,	Shee	t Metal	Mecha	anic		Construc	tion
21215-0036 hald be filed within 7 Mental Hygiene. marked other than c event, the Medical to Be Comple		7. Father's Name		,					s Name (First, Middle,		Surname)	
2121 2uld be fi June be fi marked ic event,		19a. Informant's Na		Haven Sr. ip (Type, Print)		19b. Mailing	Address (Stre		ette Ann Ca ber or Rural Route Nu		ity or Town, State	, Zip Code)
MD and 2 sho alth and m 27 is	Ļ	Rebecca 20a. Method of Dis	L. DeHa	aven / Spo	ouse				Aberdeen, 1			T
ore, gesla tof He : If he		1 X Burial 2		3 Removal from	n State cr	ematory or oth			Date		Location - City or	
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite injury or other tr	-	Donation 5 1. Signature of Fig.	Other Spenneral Service L		Coke	esbury 22. N	U.M.C. ame and Addres	Cem.	2-4-10	] <i>I</i>	Abingdon,	, Maryland
	1	Steples	1011	Juggs		1 M	cComas . 317 Cok	esbur	al Home, P y Road, Ab	.A. ingc	lon, MD 2	21009
Physician /Medical	Т	failure. List on	ly one cause o	n each line.		Do not enter th	e mode of dying	, such as ca	ardiac or respiratory ar	rest, sho	ock, or heart	Approximate Interval Between Onset and Death
Examiner		mmediate Cause ( or condition resulti		Due to (or as a c			n and e	ocarn	e use	_		Dodui
9	.	Sequentially list co f any, leading to in		b. Due to (or as a c	onsequence of)							
ted Insit Examiner		cause. Enter Unde Disease or injury t events resulting in	hat initiated	c. Due to (or as a c	onsequence of)							
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60, e be execut ysician and burial - tra		X UNPENDED					erm,E g	900 2	/18/10 TT	Las		
Box 68761  the death certificate the attending phy that for use as the thy sician/Me	2	F FEMALE: 3b. Was decedent past 12 months	pregnant in the	1 Live bir		2 Feta	al death 3	Ectopic	pregnancy	234	d. Date of delivery Month D	ay Year
Box death c death c death c d for us		Yes 2 N	No 9 Unkn		nt at time of dea n	tri 5 Oth	er (Specify)					
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Records, The law requires ficate has been signage 2 should by Completed										rmed?	death?	ompletion of cause of
tal Recision: The certifical ector, pa		5. Was case reference examiner?	red to medical		·····		26.Place	e of Death (	1 ✓ Yes Check only one)	2 IV	o 1 Yes	s 2 No
f Vit Physici er this c			2 No	Hospital: 1 In		R/Outpatient 28b Time of In		Other <sub>4</sub>	Nursing Home 5		nce 6 Other	
on o ending ath. or: Afte he fune		1 Natural	5 Pendir	(Month, I	Day,Year)	Fd 6:30	10	Yes 2 X	1 .	now mju	ary occurred	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transitedical Certification: To Be Completed by Physician/Medical Executed.		2 Accident 3 Suicide	6 X Could determ	not be 28e. Place	of Injury - At hor found at	ne, farm, street		ouilding, etc	28f Location (	Street a	nd Number or Run	al Route Number, City James Ter.
To the Hospit within 24 hour within 24 hour To the Funeraccompletely fill ledical Celedical Celedia	2	Homicide  Sa. Certifier Check only  The control of		sician: To the best					ce, and due to the caus	se(s) an	d manner as state	d.
To the Ho within 24   To the Fu completely	2	9b. Signature and		and manner sta		d/or investigation	29c. Licens		urred at the time, date		Date signed (Mon	
				M. 1	1		O.C.				uary 30, 2010	
	3		/	ho completed cause		•	Chart D	4:	4D 24204			
State	9 3	Jack Titus N  1. Date filed (Mont		ity Chief Medica	II Examiner strar's Signature		Street, Bal	timore, N	7D 21201			
Registra				2010	and d	1. Sac	Kel	<del></del> -				
DHMH 17 Rev 1/2001 OCME 2006						ORIGINAL					OCM	E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Month **Physician** Janyar 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 1 M 2 XF Days Yrs 146-38-0585 18 64 06 Director NJ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No NJ Lawrenceville 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? þe must be 34 Morton Court 08648 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify ò Specify: Caucasian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Univ. of Medicine the Medical 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired College (1-4 or 5+) 6yrs 12th grade (0-12) Advanced Nurse Practitioner @ Dentristy of No event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Elenewski Stella Kuzniacki other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau Patricia Wenczel-Sister 19 Woodmont Drive, Lawrenceville, NJ 08648 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hedwig's 2/1/10 Donation 5 ☐ Other (Specify) Ewing Township, NJ 22. Name and Address of Facility
March F/H West
4368 Wabash Ave, Baltimore, Md of Funeral Service Licer 21215 23a. Pax 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rum ediate Cause (Final **Physician** Aspiration disease or condition resulting in death) preumoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Pulmonary Disease Chronic and attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specity) 1 ☐ Yes 2 XNo 9 ☐ Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 No Other:  $4 \square$  Nursing Home  $5 \square$  Residence 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation injury eral Director: Af 1 Yes 2 No death. 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Gatheena MD

Registrar

State

EVE

31. Date filed (Month, Day, Year)

LYN

600 North Wolfe St, Baltimore, MD, 21287

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

THEUTA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ JESSE 9:00 PM FAULKNER. Oi 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD GOOD SAMARITAN BALTIMORE HOSPITAL . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F (Month, Day, Ye 296-49-05 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits Director Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20a. Method of Disposition 20b. Place of Disposition (Name of DateVIVK 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 22. Name and Address of acility PA 18434 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician. RESPIRATORY HYPOXIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ~10hrs PLUGGING MUCUS Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit CANCER ARYNGEAL that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Illnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: performed's 2 No 1 Yes To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this nartiful. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 🗓 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The desired in the de 29b. Signature and title of certifier Emoumal RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. 2020 A A B 560 | LOCH RAVER BLVD, BALTIMORE, MD

DHMH 17 Rev 7/2009

State Registrar

SHIVAKUMAR 31. Date filed (Month, Day, Year)

Amenie age Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ba 1 timore 3a110 ttopkins View Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace State or Foreign 8. Date of Birth **Funeral** 1 M 2 F Months Hours Min. (Month, Day, Year, Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 You Specify. 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) + ANAS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, WIFC '25 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 S Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Nan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. e mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final L Physician/ disease or condition resulting in death) tota Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to innectate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of Exami The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year signed by the a Yes 2 No 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examine?? 2  $\square$  No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending self-immolation 2**X** No 9:30 1 🗌 Yes 2 ☐ Accident 3 ☑ Suicide 109 Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 Digges Court Littlestown, PA 28e. Place of Injury - A home, farm, street, factory, office 4 Homicide determined building, etc. (S outside of residence Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 700043 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Goldstein Tower 100 31. Date filed (Month, Day, Year) State 32. Redistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 2018 8:20 A.M ROSE M. FINK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE ROSSVILLE ROSSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/28/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Days Months **Director** 220-24-2553 81 MARYLAND Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Modical Examiner must be notified at 1 ☐ Yes 2 ▼No Directo MD BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 7930 BABIKOW ROAD USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 9 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) JEWELRY STORE SALES PERSON 8TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANTHONY LICOTA THERESA INQUE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. SHARON DOWNEN/DAUGHTER 7930 BABIKOW ROAD ROSEDALE, MD21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 Removal from State 2/8/2010 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME 21. Signature of Funeral Service Licensee MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HTHEROSCLEROTIL Physician CARNOVASCUAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 No cate has been signed by the a page 2 should be detached it 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Funeral 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

DHMH 17 Rev 1/2001

State Registrar PAN FA 31. Date filed (M PHUADELPHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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RD # 200, RAUTIMORY, MS

DHMH 17 Rev 1/2001

Registrar

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Amend 200 per FH g900 2/12/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year John Gould 09:35 м 201 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayuiew Medical Center BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, N / A 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 174-20-4886 May 15,1927 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exercitor must be rediffed at Director MD 1 ☐ Yes 2 No Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21222 Funeral 862 Jeannette Avenue 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∃Yes 2 □ I If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Š Specify: Specify: 3 Widowed 4 □ Divorced White WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the amy injury or other traumatic event, the 1 and 2008. 10 Years Propane Serviceman Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Charles Gould, Sr. Anna Hoffmann ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary R. Gould (Son) 862 Jeannette Avenue Dundalk, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State t Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 2/6/2010 Dundalk, Maryland 4 Donation, 5 Dother (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau and Inal disease or contition resulting in death) **Physician** PNEUMONIA 1 week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. Investigation 1 ☐ Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 February 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 4940 EASTERN AVENUE, BALTIMORE, MD 21224 Narla M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day JOHN SERWIG 5:50 PM 3,2010 FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death I SAYUNA UHA GLEH BURHIE BALTIMORE-WASHINGTON MEDICAL CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** 8. Date of Birth (Month, Day, Year) 1₺ M 2□ F Months Days Hours **Director** 216-12-8449 86 Nov. 04 1923 Usual Residence of Decedent 10a, State 10b County 10c. City Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Rain Water Way 21060 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☑Yes 2 ☐ No 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, Irai pine. 12 Postman US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P. John Gerwia Mabel ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice Gerwig (spouse) 307 Rain Water Way, Glen Burnie, MD 21060 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Feb. 05 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part i, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, or use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) AIGONUTAG 2440 F /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ CONGESTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy this certificate perform 2 No 1 □Yes 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M. word way or or more proces HD

GUILLERMO JOSÉ GIANGREÇO

FEB05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Senera

29c. License number

D006551A

301 HOSPITAL DRIVE, GLEN BURNIE, HD 21061

29d. Date signed (Month, Day, Year)

PEBRUARY 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month 913 Mary Louise Medical Hill 2010 4a. Facility Name (if not institution, give street and number, Examiner 4b, City\_Town, or Location of Death 4c. County of Death Funeral 7. Age (In rs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2√□√F Months Hours Min (Month, Day, Director 219-30-8390 91 S.C. 8-1919 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6113 Carter Avenue 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No 1 ☐ Yes 2x No Specify: Completed XXWidowed 4 □ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than \* Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade 17. Father's Name (First, Middle, Last) Disabled Disabled Be 18. Mother's Name (First, Middle, Maiden Surname, ၉ Oscar Harley Essie Stalev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6113 Carter Avenue Balto, MD 21214 Theresa Hill-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Donation 5 Other (Specify) emetery, crematory or other place) King Memorial Pk 2-8-2010 Randallstown, 21. Signature of Funeral Service Licensee March East F/H 22. Name and Address of Facility 1101 E. North Avenue wans Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ MYCZA ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ATHEROSCLEROTIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant Unknown Pregnant at time of death Month the detached 9 Unknown Division of Vital Records, P.O. s been signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy performa death? 1 ☐ Yes 2 ☐ No Yes 2 [ completed filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 2 No ျ 1 🔲 Yes 1 Inpatient 2 FR/Outpatient 3 I DCA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗌 within 2 To the only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D589 M.D. February 2, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registr<u>ar</u> JOSEPH

31. Date filed (Month, Day, Yea

FEB 0 5 2010

M.D.

32. Registrar's Sonature

5601 LOCAL PAVEN BLUD BALTIMORE UND 21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Day 3, 20TO Frank George Hallameyer 6:54 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Hours Country Maryland 0272771938 212-34-5303 71 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🙀 Yes 2 🗆 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Rosewick Ave. 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A None and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked Andrew Francis Hallamever Veronica Tragester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1603 Rosewick Ave., Baltimore, MD 21237 Deborah Fuss/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremation Services 02/04/2010 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any injury or Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Servi e Licensee >0K 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ erebrova Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) o in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day detached the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy this certificate has 2 🗆 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 X No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. Accident 1 Yes 2 🗌 No Investigation Could not be completed filled in by the 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #5 Per FH G900 2/24/2010 Jh State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise Margaret Hotchkiss 2010 January 2:44 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7919 Kavanagh Road Baltimore Co. Dunda1k Social Security Number **2760** 213–34–267 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F Months Days Hours (Month, Day, Director 74 Usual Residence of Decedent 10b. County ms 23a or 28a-f sho must be notified at 10a, State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 ☐ Yes 2 ☒ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7919 Kavanagh Road 21222 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Armed Forces ō \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No 1 ☐ Yes 2 🗓 No Specify: "natural", Completed XX Widowed 4 □ Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laura Williams James Crossett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Donna Van Dine 8235 Quarterfield Road Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation Donation Specify Entlowbmen 2/3/2010 Glen Haven Cemetery Glen Burnie, MD 21. Signature of u 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter shock, or he Approximate Interval Between Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) mo **Medical** Due to (or as a consequent e of): Examiner Sequentially list conditions, if any reading to immediate cause. Enter Underlying Exami burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year the detached g Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Sal Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 × No Hospital: Other: ರಿ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Speci 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

OV

29b. Signature and title of certifie

Seema Gadillaila

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2112

D0067529

DundalkAve. DundalkMD 21272

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Per me, 896, 62/04/2010dnb | Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Lillian M. Hausner 04: 10 AM 9 2016 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square Hospital osedale Center imore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
July26, 1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2√X 216-16-4481 85 Yrs. Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at MD Baltimore Director Essex 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Wolf Street 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: Completed by Specify: White 3 □Widowed 4 □ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "ne any injury or other traumatic event, the Mode once. Elementary/Secondary (0-12) College (1-4or 5+) Management Phone Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. HUges Lillian May Campbell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hausner /son 323 Savannah Road Balto. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery 2/3/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Onset and Death Immediate Cause (Final **Physician** nopulmonar disease or condition resulting in death) /Medical Due to (or as a cons-quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) o 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown **Division of Vital Record** 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy certificate rmeg. 2 **X**No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident Subject fell 12/24/2009 **Unknown** M 1 ☐ Yes 2 🔼 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 407 Wolf Street determined 4 Homicide Essex, MD Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 2 Te the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KAMRON SALEEM MD 01, 24, 2010

State Registrar 9000 Frank

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Saleem

31. Date filed (Month, Day, Year)

10-00798 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shannon Kelly Hunt State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** 2310 hrs Shannon Kellev Hunt January 27, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Raltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign CountryMaryland Months Hours Director 217-15-1958 28 March 13,1981 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No 28a-f show or items 23a or 28a-f shor must be notified at once. Maryland 1 4 1 Baltimore should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4434 Newport Avenue U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married White, etc. Yes 2 x No Divorced If Yes, Give Year nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. 3 Widowed 1 Yes 2 X No specify: White Specify ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 4 Administrative Coordinator Public Health 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Roger Hunt Francine Baker 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Hunt (Mother) 8801 Sandrope Court Columbia, Maryland 21046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 1 - 31 - 2010Glen Burnie, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licer Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part I. Enter the diseas implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical \* AMENDED 6 per fh g900 2-26-10 vt UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown obesity, post surgical state Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes ဥ No 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural 5 Pending 1 Yes 2 No vithin 24 hours after death. the To the Funeral Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 29, 2010 **OCME** Name and address of person who completed cause of 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State Registrar gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:00 AM e 40 2010 Holmes Jeorai /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita If Under 24 Hrs. 8. Da Birthplace (State or Foreign Country) 8. Date of Birth Alor. 28 . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Min 1**X**M 2□ F 212-26-1494 Yrs Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State or 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, Ital Nocinal Examinat must be notified at 1 Mes 2 No Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Types 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Blac Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. CO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Be Pages 1 and 2 should be tolmes 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a.IInformant's Name/Relationship (Type. Print) 514 Kourdview permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-12-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 5151 Balto. Natil 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown olitis Were autopsy findings available prior to completion of cause of death? autopsy performed 2 HNo 2 No 1 □Yes 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Watural 5 Pending the Funeral Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore S. Hanover 001 31. Date filed (Morfith, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G900, 2/16/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of De 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruby Mae Harper O3<sup>Day</sup> 20 Ï n 12:16a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min 10 donth, 63 Country) 426-78-3660 Director 35 74 MS Usual Residence of Decedent show 10b. County 10a State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director iral", or items 23a or 28a-f st Examiner must be notified Baltimore Randallstown MD 1 🗆 Yes 2 🔀 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8527 Brest Road 21133 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Black Specify: Completed 3 X Widowed 4 Divorced ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nentary/Seconday (0-12) College (1-4 or 5+) 8th grade Domestic Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked ot မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Mary Smith Jim Little Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8527 Brest Road, Randallstown, Md 21133 Gloria Harper-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 13<sup>Date</sup> 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Druid Ridge 4 ☐ Donation 5 ☐ Other (Specify)  $2/\frac{11}{10}$ Pikesville, Md 21. Signature of mineral Servi 22. Name and Address of Facility
March F/H West 4 300 Wabash Ave Baltimore, 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ne cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ate has been signed by the atte page 2 should be detached for r in the past 12 months?

1 Yes 2 No Day Year 1 Yes 2 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 2 No 3 □ Probably 4 □ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 No Yes 2 WING 1 Yes the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Hospital: Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗭 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident M 1 Yes 2 No Investigation 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 3

title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

only one) 29b. Signature Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Box 68760. P.O. Records, Division of Vital within 24 hours after d

To the Funeral Direct

completely filled in by

State Registrar DHMH 17 Rev 1/2001 29b. Signature) and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature Person

30. Name and address of person who completed cause I death (Item 23a) (Type, Print)
Susan Easky wo all A Majothy Beach Rd

29c. License number

D56741

Pasadena, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norma J. Hooper 01 2010 :36 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛭 F Months Hours Min (Month, Day, Year, Director 06/20/1932 219-28-1564 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō Funeral 23a 11122 Pfeffers Road 21087 U.S.A. items. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates. "natural", 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. . Page 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Florist Family Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George Pleines Dora Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 19 Offspring Court - Perry Hall, Maryland 21128 Steven Hooper (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 
Burial 2 
Cremation 3 
Removal from State 4 Donation 5 Other (Specify) 01/29/2010 Baltimore, Maryland Crematory. Inc Signature of Funeral, Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary disease or condition resulting in death) years Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any leading to inmedicause. Enter Underlying Dinn to for an a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Year Month Dav 1 Yes 2 7 9 Unknown been signed by the should be detached 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performe Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 🗷 Natural 5 Pending after death. Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R149194 28,2010

State Registrar 51

Towson

MD

21204

N. Charles

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

Grant

Vear) 05

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ladeline Klein		State of Maryland / Department of Heather State   1. For State   Registrar   Certificate of Deather   Certificate   Certific		Reg. No. 2010	03136					
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redical Exami		4a. Facility Name (if not institution, give street and number)  4b. City	y, Town, or Location of Death	4c. County of Death	1					
- Francisco			napolis  nder 1 Year   If Under 24Hrs.   8. Date of	Anne Arundel Birth(MM/DD/YYYY) 9. Bir	thplace (State or					
Funeral Director				Foreign						
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
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eath with items 23	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	edent of Hispanic Origin? (Specify Yes or ecify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - Amer White, etc.	ican Indian, Black,					
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212 ould be I Menta marke	To B	1111	ess (Street and Number or Rural Route N	A Lambert Colonia Colonia	, Zip Code)					
MD nd 2 sho alth and m 27 is		Mr. Robert Dale Klein/Son 302 Rugb  20a Method of Disposition (No. 120b. Place Of Disposition	y Cove Rd. Arnold,	Md. 21012	Town State					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shining or other traumatic event, the Medical Examiner must be notified at once		1 X Buriat 2 Cremation 3 Removal from State crematory or other plan			nore, Md.					
Balti permit Departm Imports injury o			Ruck Towson Funera	al Home, Inc.						
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a <u>Hypertensive atheroscle</u>	rotic cardiovascula	r disease	Between Onset and Death					
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.								
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8760 ificate b	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	y Day Year					
Box 6876 e death certificate the attending phy	Physician/M	past 12 months?  4 Pregnant at time of death 5 Other (S		Ì						
that the de detached f		Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I. 23e. Die	d tobacco use contribute to	the cause of death?					
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Vital ysician: his certi	o Be	25. Was case referred to medical examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 V ER/Outpatient 3	26.Place of Death (Check only one)  DOA Other: Nursing Home 5	Residence 6 Othe	r.					
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b Time of Injury	28c. Injury at Work? 28d Descrit	be how injury occurred						
Divisi	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factor (Specify)	ory, office building, etc. 28f. Location or Town	n (Street and Number or Ru n, State)	ıral Route Number, City					
To the Hospi within 24 hou To the Funer completely fi	Medical C	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in								
7 × × 0	Me	and manner stated  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo						
		D_M Lim	O.C.M.E.	February 4, 2010						
			n Street, Baltimore, MD 21201							
S Regis	ate		, ,	-						
DHMH 17 Rev 1/2		ORIGINAL								
OCAME 2006										

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Reg. 8900,02/04/2010dnb Certificate of Death For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Franklin January 2010 11.15 Krepner Medical Laurence 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 8/30/1921 1**X** M 2 □ F Months Days Hours Min. Country)
Maryland Director 220-03-9785 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 XNo Maryland Baltimore Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21221 U. S. A. 907 Boundbrook Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XXYes 2 \( \text{No}\) No If Yes, Give Year or Dates. Rlack. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Ship Building 9 Crane Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gertrude Hill Louis Krepner Department of Health and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Boundbrook Way Essex, Maryland 21221 Miami Virginia Krepner (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 265o 4 ☐ Donation 5 ☐ Other (Specify) <u> Marvland Veterans Cemetery</u> Garrison Forest, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, Maryland 21221 Low 23a. Part 1. Enter the disease, or complications that is shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 45064 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of CERTIFICATION APPROVED BY MEDICAL EXAMINER cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year 1 Yes 2 0 2 No been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown eumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 XNo 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: s after death. I Director: After t 28d. Describe how injury occurred iniury work?
1 ☐ Yes 2 🛣 No Natural 1 Natural 2 X Accident 5 Pending 01/12/2010 Unknown Subject fell Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 907 Boundbrook Way, Essex, MD 4 Homicide determined Home 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) OU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 Mace

Registrar

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 1:35 PM ENNETH 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Rosedale Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min. Director 220 09 2718 1919 May 14. Marvland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If liem 27 is marked other than "notion." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 332 Miles Rd. 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Completed by Black, White, etc. 1 X Never Married 2 ☐ Married 1 X Yes 2 No 1 ☐ Yes 2 X No Specify: Year or Dates. **WW** II White Specify: 3 Divorced 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Steelworker Steel Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerry Krecher Jeanette McCafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Krecher (Brother) 332 Miles Rd. Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Inc. 2/4/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service bi 22. Name and Address of Facility W Bruzdzinski Funeral Home P.A 1407 Old Fastern Avenue Esse Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year signed by the a Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 \$\vec{\mathbb{M}}\$ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy nis certificate h I director, page death? 2 No \_ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ဂ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: I **Director:** After to a din by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. Signa

Registrar

DHMH 17 Rev 7/2009

State

Name and address of

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4b, c. perPHYS, G900, 2/17/2010, WS
State of Maryland Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 4,2010 Year 3:26A Naomi B. Kidd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holly Hill Manor Towson <u>Baltimore</u> Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 1 Year 1 □ M 2 🗓 F Months Days Hours January <sup>Year</sup>, 191β Director Yrs. 97 165-16-1461 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10h County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Perry Hall 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 USA 9507 Kingscroft Terrace Apt.K 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 Midowed 4 ☐ Divorced Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ced other than " Elementary/Seconday (0-12) College (1-4 or 5+) 10 Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ဂ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e George A. Kidd: Mary E. Bower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9507 Kingscroft Terr. Perry Hall, Md. 21128 Garland R. Kidd Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 2-9-2010 Middle River, Md. Holly Hills Schimunek Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Zhours Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for it in the past 12 months? Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 2 1 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, D Year! Natural injury 5 Pendina work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item e 0 Houl 31. Date filed (Month, Day, Year) State FEB 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Michael 2010 Lawrence Kuczinski 10:02 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Jan. 26,1948 1XIM 2 🗆 Hours 62 Director 214-48-1815 Usual Residence of Decedent show 10b. County 10a. State 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Anne Arundel 1 Yes 2 X No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1523 Marco Drive 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lead Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Stephen Joseph Kuczinski Marion Barry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Michelle Williams/Daughter 1523 Marco Drive Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February Department of Important: If it any injury or o cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Glen Haven Mem. Park | 8, 2010 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MOIIZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ ericar dia Trimpon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami burial-transi Myocardia TUE and that initiated events resulting in death) Last Due to (or as a consequence of) ending physician ar use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be in 24 hours after death. the Puneral Director: After this certificate has been signed by the attending physician pleted filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Year ☐ Pregnam.☐ Unknown Pregnant at time of death Month Yes a Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 🗌 Yes 2 HNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 \( \text{Yes} 2  $\square$  No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 1014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Gren Burnie Mo 2061

State Registrar

DHMH 17 Rev 7/2009

Kelly L. Milles

FEB 0

31. Date filed (Month, Day, Year,

MO

1417 Madison Part

32. Registrar's Signature

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Physici Medical Exami								2. Date of D Month January	Day	Year	3. Time of Death 0849 hrs
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Division of Vital Records, P.O. Box 68760, rad or Attending Physician: The law requires that the death certificate be expressed death.  al Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	me of pregr	_	etal death 3	Ectopic pr	egnancy	23	<ul> <li>d. Date of delive</li> <li>Month</li> </ul>	ry Day Year
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Div	Certification:	4 Homicide determi	ned (Specify)	resid	ence			Bel Air	State) (	310 Cobu	rn Ct.
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical (		sician: To the best of m								
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	l	30. Name and address of person wh Russell Alexander MD.	o completed cause of c Assistant Medic	,		1 Penn Street	, Baltimore	, MD 21201			
		31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	have	1					
Regist	rar	JAN 1 4 2010	Lanson	Mit.	The second					OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23c per doc g900 2-5-10 yt.

Begar mend of Health and Mental Hygiene

			For State Registrar	State of Mary		Certificate of L			erie g. No. 🤈 🦳 📗	0311.2
	Physicia	an	Decedent's Name (First, Middle,				2	. Date of Death Month	Day Year	3. Time of Death
	/Medic	ai	4a. Facility Name (If not institution,	-	andall	Linkous	Location of Death	anuary	29, 70/C	
	Examin		_		center	in in	osedale	0	1 1	110/4
	Funeral Director		Franklin Square 5. Social Security Number 214-56-5692	5. Sex 7. Age (I	n yrs. last birth		If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Jan. 7,	Year) 9. Bir	thplace (State or Foreign buntry)
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	with the	by Funeral Director	10e. Street and Number  329 South Tay	lor Avenue		10f. Zip Code	21221	10	g. Citizen of What Co United St	
	ems 2	ınera	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H If Yes, specify Cuba		fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	erican Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evanthar must be notified.		1 ☐ Never Married 2  Marrie 3 ☐ Widowed 4 ☐ Divorced			7.7	Specify:			Thite
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Linkous, James altimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationsh Mrs. Anna Linko	p (Type. Print)		Mailing Address (Street 329 South Ta				
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i i	permit. Pages 1 and 2 st Department of Health an Important: If item 27 ls any injury or other traur once.		4 □ Donation 5 □ Other (Sp 21. Signure 1 neral Service L	ecify)	Hillton	Service Co			Towson, N	-
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Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		ontiont 3 DOA Oth	26. Place of Death			
n of	ding Phys	on: To	1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y		me of 28c. Injury Wor	ry at 28		nce 6 Other (Spewinjury occurred	ecify)
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be	- At home, fari 'Specify)	M 1 □ m, street, factory, office	Yes 2 □No 28	f. Location (Sti City or Town	reet and Number or F , State)	ural Route Number,
	Hospita 24 hours Funeral	Medical C	29a. Certifier (Check only one)  1 Certifying 2 Medical E	Physician: To the best of r xaminer: On the basis of ex and manner state	xamination and	death occurred at the ti	me, date and place, a opinion, death occurre	nd due to the ca	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed (Mon	
			30. Name and address of person v	KAMAON 5	ALEEM 1	None Print	0000		01, 29, 201	0
	81		Dr. Hamron So	leem 900	o Fra	Type, Print)  nKlin Squ	are Drive	Balt	imore, MI	0.21237
	Sta Registr		31. Date filed (Month, Day, Year) .	2: Registrar's	Signature	and de		•	ē	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03143 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Loukonen Martha Josephine 8:55 P M January 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Genesis Heritage Nursing Home Baltimore Co. Dundalk 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min 217-22-5066 Director June Pennsylvania Lisual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Dunda1k MD Baltimore 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7232 German Hill Road United States · death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2XXNo Specify Specify: Completed 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Battle Monument School Elementary/Seconday (0-12) College (1-4 or 5+) Substitute Aide Education Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o မ Frank Heidel Sylvia Lear traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8522 Hydra Lane Nottingham, MD of Health David Demoine (Friend) other Baltimore, Important: If ite any injury or oth once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hill top Service Corp. 2/4/2010 4 ☐ Denation 5 ☐ Other (Specify) Towson, Maryland o funeral atur Name and Address of Facility da-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, Maryland art 1. Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final IRA TOR Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner UMONI quentially hat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transit and that initiated events resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year detached 9 Unknown Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe ( Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has sted filled in by the funeral director, page 2. performed 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death heck only one) examiner? Hospital 1 Tes 2 No Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **V** Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined 24 hours after Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 e of death (Item 23a) (Type, Print) flace Dundalk ND 21222

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 25 per me, 2900, 02/04/2010dhb Red, No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MORRIS JANUARY Year **Physician** LANE 7:00 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS BALTIMORE BAUVIEW MEDICAL CENTE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 7-128-2001 Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, if a Medical Examiner must be notified at 1 XYes 2 ☐ No Director alt more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 ILSA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?. 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 Never Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Black Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Becton 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. MOVVI ane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 timore relton Method of Disposition
19 Perial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Baltimae, 2010 MO 21. Signatur of uneral Service Leensee 22. Name and Address of Facility towell MD 21207 Heights 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRAL **Physician** HEMORRHA WEFK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-transit Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? las autopsy performed page certificate 2 No 2 🗆 No 1 ☐ Yes funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**X** Yes <del>2.</del> √No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ≯ 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number

RES - 000 29b. Signature and title of pertifier 29d, Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AZMIN MORAUES-OCIA MD. EASTERN AVE, BALTIMORES

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 per fit good 2 Health and Mental Hygiene 2 1 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Lie Liu 2010 1:05 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 □ M 2🏋 F Hours Dec. 15, 1915 Country) China 94 **Director** 212-79-2825 Yrs Usual Residence of Deceden 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12630 Viers Mill Rd. **#702** 20853 China Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 ☒No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Asian 3XXWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (Unknown) (Unknown) Liu Juwu Feng Zhang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12630 Viers Mill Rd. #702, Rockville, MD Fang Song / Daughter 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Chesapeake Crematory | 2/4/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any in once, MO1555 22. Name and Address of Facility Rapp Funeral and Cremation Services Close Sta Silver Spring, MD 933 Gist Ave.. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Convestive Heart Failure Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, <u>Cerebrovascular Accident</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop performed 2XXN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🛣 No 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify Hospice IPU 1 Inpatient 2 ER/Outpatient 3 DCA this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . Kouertchou D63748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kouatchou M.D., 6001 Muncaster Mill Rd., Rockville, MD 20852

DHMH 17 Rev 7/2009

State Registrar 31. Date filed

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4b. City, Town, or Location of Death Examiner 4c. County of Death MUKOMG Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Director or items 23a or 28a-f shov 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10d. Inside City Limits must be notified at **Funeral Director** URTOWSYILLE 1 X Yes 2 No 10g. Citizen of What Country? 20866 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Completed by 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3. Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KWON 19a. Informant's Name/Relationship (Type, Print) (1404 Liter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State SILVER SPRINK IND 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ micro disease or condition Medical resulting in death) Due to (or s a consequence of) **Examiner** Sequentially list nanditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 KNo 1-Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 🗌 Yes 2 🗌 No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Let Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cyrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68049 eema 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

seema

31. Date filed (Month, Day, Year)

arroll

Takoma

7600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** QW6 /Medical Facility Name (If not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Ralhim 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Min 60 Director Usual Residence of Deceder death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore Director 1XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? E. Federal Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Lewis ပ Sinclair 1 M Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral S 23a. Part 1. Enter the diseas shock, or heart failure. ease, or complications that caused the death. Do not enter re. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760 the attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Hospital or Attending Physician; The law has 24a. Was an autopsy certificate Division of Vital 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 \sum Nursing Home Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director: ...
completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifie 30. Name and address of who completed cause of death (Item 23a) (Type, Print) 28 BORMD (Month, Day, Year) FEB 0 5 2010 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Wilbert Mattes. Sr. Jamuary 20°f0 10:45 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Davidsonville Anne Arundel Krisleigh Assisted Living Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 10<sup>M</sup>27<sup>n</sup>-1925<sup>ar)</sup> 84 Mary Yand Director 216-20-5943 Usual Residence of Decedent or 28a-f shov 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Anne Arundel Davidsonville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21035 U.S.A. 1401 Monforte Drive 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WII 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) General Motors Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Punte Frederick Mattes permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Monforte Drive Davidsonville, Maryland 21035 Mr. William W. Mattes, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 01-28-2010 Baltimore, Maryland 21. Signatu of "Ineral Service Li∞ see 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Mim Baltimore, Maryland 21214 23a. Part 1. Enter the diserce, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ead time. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (d as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Year ed by the a detached t 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ cate has been signated bage 2 should b Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate h 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury work? ✓ Natural 5  $\square$  Pending injury 2 🗌 No Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the 29b. Signature and the of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day V ar)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ February 20°10 11:25 Ρ. Gloria Moore Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min Mary Tand 84 1925 Director 213-20-5969 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City Md. 1 Yes 2 X No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21042 5330 Dorsey Hall Drive #221 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ William н. Lena Contarini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Son 1398 Revere Rd. Yardley, Pa. 19067 Mr. Bernard L. Myers, Jr./ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 X Other (SpErritombment orraine Park Cem. 2-5-10 Woodlawn, Md. 21. Signature of Hyneral S 22. Name and Address of Facility F RUCK TOWSON F 1050 York Rd. Funeral Home, d. Towson, Md: 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fracture disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any Leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): inding physician use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 — Yes 2 No Por ☐ Pregnant at time of death ☐ Unknown Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate Yes 2 WNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 DO Other (Specify) NOSPUL Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural
Accident 1 Natural 5 Pending Fall within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No Investigation 6 Could not be Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 330 Darsey Hall Dave, Columbia mo Assisted Wing-facilitz Medical \*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

harves CF Tonson

HARUES M

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician PM 81.20 2010 /Medical Charles Edward Marshall 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner anklin Square Hospital Q\_ timore Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ★M 2 □ F Director West Virginia 235-46-6793 5/8/1932 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, the Medical Example of modified at Director 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Bladen Road Funeral 21221 S. A. permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, its Medical Ext. in action 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 XYes 2 ☐ No 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Marshall Charle Baltimore, Maryland 21215-0036 1949 1952 1 ☐ Yes 2 🛛 No Specify 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Foreman Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Frank Marshall Tina Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Sue Marshall (Wife) 101 Bladen Road Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8 2010 4 ☐ Donation 5 ☐ Other (Specify) Baptist Ch. Cem Farnham, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Fssex, Maryland 21221 Sr Part 1. Enter the disease, or complications will caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a P.O. 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Division of Vital 2 **N** No 1 □ Yes 2 🗆 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death he Funeral Director: A pletely filled in by the fi 2 Accident investigation 1 □Yes 2 □ No ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) BINH NGUYEN 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2010 30. Name and address of person who competed cause of death (Item 23a) (Type, Print) 21237 31. Date filed (Mo State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Year 7:45 PMM Frederick Muller Medical January 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Ivy Hall Geriatric Center</u> Middle River Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1**X** M 2 □ F Days Hours (Month, Day, Year) 9/23/1926 Director 377-22-1421 83 Wisconsin Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No <u>Pennsylvania</u> Cumberland Camp Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 Center Street 17011 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Yes, Give Maryland 21215-0036 1 Tes 2 No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Sign Manufacturing Painter permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alexander Muller Amelia Diener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Mark Heidel (Nephew)</u> 12781 Grace Court <u>MT 4843</u>9 Grand Blanc Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State /2 4 Donation 5 Other (Specify) Bayview Crematory 2010 Middle River, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Asperation meumonia disease or condition resulting in death) Medical as a consequence of) Examiner metastate Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Diseas Joint death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 1 Yes 2 9 Unknown P.O. been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical 29a Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) MD D31464 2/2/10

∫ √ State

Registrar

DHMH 17 Rev 7/2009

SHOAIIS A

31. Date filed (Month, Day, Year

821 N. ELLTAN ST Shike 308 BALTIMORE MD 21261

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Day 2010 Year Mary Lee Murphy Jan.31 3:00 A.M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death N/A Fayette Health and Rehab. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 FF Months Hours (Month, Day, Country) Carolina 238-24-1773 Director 1923 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits N/ABaltimore Maryland Yes 2 No 10f. Zip Code 21 21 7 5 10e. Street and Number 827 N. Arlington Avenue Apt. 209 10g. Citizen of What Country? 23a Funeral USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 72 hours after 2 No Maryland 21215-0036 Black 1 ☐ Yes 2 ☐xNo Specify: 3 🗌 Widowed 4 🙀 Divorced Completed Year or Dates the Medical 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Catering Service Waitress 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hezekiah McNair Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 N.Bend Road Baltimore, Maryland 21229 Frank McDougald /nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/6
Western Star Cemetery 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD 21. Signature of Juneral 8 Lions 22. Name and Address of FacilitChatman-Harris Funeral Home 21215 ance 5240 Reisterstown Rd Baltimore, MD 23a. Part 1. Inter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. I \_\_\_\_diate Cause (Final Onset and Death Physician/ ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 6 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): MENINGIOMA and burial-tran Due to (or as a consequence of): resulting in death) Last DISORDER the attending physician Physician/Medical SEIZURE To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No for Month Day Year 9 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed NA 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation 6 Could not be the Accident Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) ATTENDINZ 00057948 0105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

DHMH 17 Rev 7/2009

JMO

31. Date filed (Month, Day, Year)

FEB 0 5 2010

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32. Registrar's Signature

answer 10 2169

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	otate of waryland		rtificate of	Death	F	neg. No.2010	03153
	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year						3. Time of Death			
П	Physicia /Medic		EVELYN	М. М	ILES			FEBRUAL		11:45 P.
The state of	Examin		4a. Facility Name (If not institution, given	ve street and number)				Death	4c. County of Death	
A.			GENESIS CROMWELL				ESVILL		BALTI	
	Funeral		5. Social Security Number 6. S	Gex 7. Age (In yrs. la 1 ☐ M 2 💢 F	a <i>st birthday)</i> Yrs.	If Under 1 Year Months Days		Min. (Month, Day		nplace (State or Foreign untry) (LAND
1	Director		217-58-3570 Usual Residence of Decedent	59				5/2/195	MAN.	LLAIVU
	land ow	ŀ	10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Mary f sh	흐	MD BALTI	MORE	CARN	ΙΕΥ				1 ∐Yes 2 ∐XNo
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cor	untry?
	3a o		9226 THROGMORTON	ROAD		2	21234		USA	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	lispanic Origir an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	
9	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Evandria mat Le natified at		1 Never Married 2 Married	1 ∐Yes 2√ No If Yes, Give Year or Dates:	1	1 □Yes 2 XNo			Specify:WHI'	re:
21215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced		10- Davi	edent's Usual Occup	nation		16b. Kind of Business/	
<u>7</u>	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	e kind of work done DO NOT use retire	during most o	f working	TOD. TAILS OF BUSINESS.	
12	within ene. than	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)		MUSCIAN	/		SELF EMPI	LOYED
2	Hygid Hygid ther	ပ္	17. Father's Name (First, Middle, Las	4+ YEARS		PIODOLIN	18, Mother's	s Name (First, Middle,	Maiden Surname)	
an	d be ental ked o	To Be	LAWRENCE MILES				AN.	VINA GOOD		
Maryland	should be nd Mental marked c	1	19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street	and Number	or Rural Route Numbe	er, City or Town, State, 2	Zip Code)
S S	and 2 sealth ar n 27 is	1	JOEL CHIRALO/HUSE	BAND	9226	THROGMO	RTON RI	CARNEY	MD 21234	
re,	s 1 al		20a. Method of Disposition	20b. F	lace of Disp	osition (Name of ematory or other pla	ce)	Date	20c. Location - City or	Town, State
E	Pages nent of ant: If its ary or o	H,	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donațion 5 ☐ Other (Spec	I Removal from State 1				2/3/2010	CATONSVILL	E, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar mant to an alliance at once.		21. Signature of Funeral Service Lice	ensee MO1139	2	22. Name and Addre	ess of Facility	THE JOHNS	ON FUNERAL	HOME, P.A.
<u> </u>	8978	20 /	Heath Ha	y -Davsor		8521 LOCH				1286
			23a, Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the deat y one cause or each live.	h. Do not er	nter the mode of dy	ing, such as c	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician	r i	Immediate Cause (Final disease or condition	-a HOUC	na	1 ch	COM	910001	Mamons	<u></u>
1	/Medical Examiner		resulting in death)	Due to for as a conseq	ueno (1):	c 1	min	dina	ne_	
	Lxammer	_	Sequentially list conditions,	b. Due to (or as a conseq	u por of):	tCA1	1/4	1 [lunc	100	
	ted isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq						
	execu al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):					
68760,	tificate be executed ig physician and as the burial-transit			_ d.						
89	tificat ig phy as the	Medical								
Box		N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnan	icv		23d. Date of de Month	livery Day Year
O. B	deat of for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of o		Other (specify)			World	Day
P. C	Physician: The law requires that the death cer this certificate has been signed by the attendir ral director, page 2 should be detached for use	Physician/	9 Unknown  Part II. Other significant conditions	contributing to dooth but not ros	ulting in the	underlying cause d	iven in Part I	23e. Did	tobacco use contribute t	o the cause of death2
<u>ဟ်</u>	res th	2	Part II. Other significant conditions	contributing to death but not res	diting in the	andenying cause g	Well III I Giv II	1 🗆	Yes 2 No 3 F	robably 4 Unknown
Records,	requi	Completed						245 14/55	24K Word	utancy findings available
Sec.	e law has t	ם						—— 24a. Was	ormed2/   death?	utopsy findings available completion of cause of
alF	ician: The l certificate ha ector, page						00 8	1 □Yes		s 2 No
of Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	I EB/Outpot	ant 2 🗆 DOA 01	de e vi	of Death (Check only	idence 6 ☐Other (Sp	ecify)
ō	Physic this aral di	1:1	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time	of 28c. Inj			how injury occurred	
on	Attending Phyrdeath. ccoper: After this by the funeral of	tio	11 Natural 5 Pending 2 Accident investigat		Injury		ork? ⊒Yes 2.⊒N	No		
Division	Atter	Hice	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iome, farm, s	street, factory, office	1	28f. Location	(Street and Number or F wn, State)	Rural Route Number,
ă	salor safte al Dir ed in	Certification:								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin	owledge, de ation and/or	ath occurred at the investigation, in my	time, date and opinion, deal	d place, and due to the th occurred at the time	e cause(s) and manner : , date and place, and du	as stated. re to the cause(s)
	the hin 24	Medical	one)	and manner stated.	^	29c Lice	nse number		29d. Date signed (Mor	oth, Day, Year)
	5 viti		29b. Signature and title of certifier		()	5	359	3.	2-2-2	
			20 Norto and address of paragraph	on completed cause of death (the	m 23a) (Tun	e Print)	7-01	20 001.	017. 20L	
/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 TO OLG MUC SUIT 208								
	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature									
	Registrar FEB 0 5 2010 Deneur S. Januar									
DH	HMH 17 Rev 1/3	2001			,	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Feb Day 2010 Year Albert Bruno Mikalajunas :50PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Drive Baltimore Halethorpe 1105 Meadowlark 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Month, Day, 1 🕅 M 2 🗆 F Months Days Hours Min. 220-14-2232 Director 1922 87 June Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** must be notified 1 🗆 Yes 2 🖺 No MD Baltimore Halethorpe 5 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a 1105 Meadowlark Drive 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 8 aluminum press operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | ပ္ Alexander J. Mikalajunas Karolina Buchness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Mikalajunas-daughter 22 Ridge Road, Catonsville, MD 21228 of Health If item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Odenton MD West Arundel Crematory 2-5-2010 Donation 5 Other (Specify) Ambrose Funeral Home Inc. re Funeral Serv 22. Name and Address of Facility 1328 Sulphur Spring Road Arbutus MD 21227 Part 1. Enter the disease: or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ prostat Medical resulting in death) e to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a conse quence of) the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 🗆 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?. Yes 2 N 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 (Residence 6 ☐ Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only or 29b. Signati 29c, License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

BALTIMORE

ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, per MD 9900 2/5/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Day Month Year **Physician** Proctor Criadys MAXWell :15 P M ()an 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1tarford mardi Forcs t 77:11 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2€ F Yrs. Director 217-14-2723 Oct. 20, 1917 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, the Mudical Exerciner rust be notified at 1 Yes 2 No Director Marvland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Items 23e 2030 Mardic Drive 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. i filed within 72 hours after de l Hyglena. other than "natural", or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩idowed 4 Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Retail Furniture Store Pages 1 and 2 should ba filed v nent of Health and Mental Hygle ant: If item 27 ie marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Elwood Proctor Bessie Irene Daughton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Deportment of Health a Important: If item 27 is any injury or other tree Carmen Sakell / Daughter 2030 Mardic Drive, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State `4 Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn 2-5-10 Bel Air, Maryland 21. Signature Mineral Pervice Ligenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Tweek CUA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 4SCUD Sequentially list conditions, Dualto (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Box ( IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 🗆 Unknown à signed t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Chronic 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? SICK 54 notrone autopsy performed? demenina 2 No Yes 2 1 No 1 Yes the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home Residence 1 ☐ Yes 2 ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his After thi funaral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeref L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31291-2/1/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 Bass MO 16/052 31. Date filed (Moun, Day, Year) 32. Registur's Signature

DHMH 17 Rev 1/2001

State

Registrar

2010 ▶

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael Manning	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death  Reg. No.	13   5 6
Physician/	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year	
Medical Examine	Michael Manning January 25, 2010 2200	3 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Baltimore	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (S	itate or
Director	579-96-2020 14M 2 F 35 Yrs. 06/03/19/4 Country)	PA
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Insi	ide City Limits
and show	Baltimore 1 NO	es 2 No
Maryli 28a-f d.at.o	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	-
th the 23a or notifie	2117 Brookfield Avenue 21217 USA	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian White, etc.	1, Black,
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ours after a stural a samine con by	45 December 5 duration (Constitution of Constitution of Consti	
5-0036 ed within 72 hour hygiene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	_
-003 I withi giene.	12th Grade   Barber   Self-Employe	<u>∌d</u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		
21, 21 d Mer is mar tic ever	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med To Be Comm	Angela Manning (sister) 9134 Springhill LN. Greenbelt, MD 207	
Ore, es l a of He If ite	1 1 Burial 2 Cremation 3 Removal from State crematory or other place)	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other fr	4 Donation 5 Other Specify: Glenwood Cemetery 02-09-10 Washington, DC 21. Sphature of Funeral Service Licensee 22. Name and Address of FacilityTRI-State Funeral Service Control of Funeral Service Control of FacilityTRI-State Funeral Service Control of Facility TRI-State Funeral Service Control of Fac	3 CAC
Bal Permi Depar Impo injur	January & Washington, DC 2	
Physician	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approx	imate Interval
Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds	en Onset and Death
ZAGIIIIICI	or condition resulting in death)  Due to (or as a consequence of):	
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
rim im	cause. Enter Underlying Cause  (Unsease or injury that initialed Due to (or as a consequence of):	
Hed K	events resulting in death) Last Due to (or as a consequence of):  d.	
50, te be executed ysician and bunial - transit	UNPENDED AMENDED	
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Box 6876 e death certificate the attending phy ed for use as the b	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  4 Pregnant at time of death 5 Other (Specify)	Year
). Bo; the death by the att suched for Physi	1 Yes 2 No 9 Unknown 9 Unknown	
Vital Records, P.O. B ysician: The law requires that the d his certificate has been signed by the director, page 2 should be detached o Be Completed by Phy		
ds, F quires en sig uld be	24a. Was an 24b. Were autopsy find	
Records, The law requires fricate has been signage 2 should be Completed	autopsy prior to completion performed? death?	
tal Rection: The certificate ector, page		2 No
/ital /sician	examiner?	
of Vi	27. Manner of Death 28a. Date of Injury Mogth Day (and Da	
ision Attendi r death. rector: by the fi	Natural 5 Pending 2 Accident Investigation 2130 hrs 1 Yes 2 No Subject Shot	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th nours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.  Certification: To Be Completed by P	3 Suicide 6 Could not be determined 4 Homicide 4 Homicide 5 Could not be determined 6 Specify Alley 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State) 1900 Aisquith Street, Baltimore, MD	Number, City
Hospi 14 hou Funer Funer Full fil	The proof of the control of the cont	
To the Howithin 24 Protection Completely	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s	)
A FINAL E	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	'ear)
	O.C.M.E. January 26, 2010	
	30/Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	e 31 Date filed (Month, Day, Year) 32 Registrar's Signature	
Registra	p. p. marine	
DHMH 17 Rev 1/2001 OCME 2006	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FeB 38 AM 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Ratimer Hospital 150 Himor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Min. 12 M 2 ☐ F Months Days Hours Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Midlical Examinar must be notified at Director 1 Yes 2 □ No SALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or 2121 WINSOR U.S.A 21201 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 than "natural", or 1 ☐Yes 2 No Specify. δ Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 276 485 OWNER permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygin Important: If item 27 is marked other i any Injury or other traumatic event, Ib 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of Funeral Service Licensee AROLZNE JI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MUOCALDIAL dat disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner the roscleration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, physician Physician/Medical as the t attending p IF FEMALE: yes, outcome of pregnancy
Live birth 2 ☐ Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the detached t signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by toilur 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25. Was case referred to medical examiner? this certificate 2 2 □ No of Vital 1 □Yes 1 Yes funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) erson who comp ed cause of death (Item 23a) (Type, Print) 30. Name and addr Fran

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State Registrar Date filed (Month, Day,

Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pebruary 1, Year 1, 2010 2:48 PMM Physician/ Jean S. Nash Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery Olney 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) g Birthplace (State or Foreign) Funeral 1 □ M 2 🏿 F Days 83 (Month, Day1 Year) 1926 Virginia 225-30-9113 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20882 United States 22414 Sweetleaf Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 K Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Medicine Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude May Adams Guy Hubbard Schuler Page 1 and 2 should be ment of Health and Ments 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chandler /Daughter 22414 Sweetleaf Ln. Gaithersburg, MD 20882 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb 05 1 Burial 2 Cremation 3 Removal from State Beltsville, MD Inc 2010 Chesapeake Crematory 4 Donation 5 Other (Specify) Name and Address of Facility
Rapp Funeral & Cremation Services M00382 John 933 Gist Ave. Silver Spring Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arebro vasculon acetalent Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Adrial Filo lighen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Box 68760 P.O. Records, Division of Vital filled in by the

5 Pendina

Investigation

determined

anistopher I. ways, ms

Repun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Accident

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

3 Suicide 4 Homicide

29a. Certifier

Medical

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

139793

1811 Prince Philip Drive, day, mg

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d State Phylaryland 76 Barthent Ja Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16:50P M MARY POWELL abreal Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death HOSPITAL BALTIMORE OF Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Hours MAY 16, Director 245-22-0216 NC Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **4210 COLBORNE ROAD** 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Completed by 1 Never Married 2 Married 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates BLACK permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRACTICAL NURSE HEALTH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **BRUIN HAYNES** CARRIE BARBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES W. HAYNES/BROTHER 4210 COLBORNE RD. BALTIMORE, MD Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. AUBURN CEMETERY 2-8-2010 BALTIMORE, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 4 | Pregnant a 9 | Unknown 1 Yes 2 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural  $5 \square$  Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month. Dav. Year) 02/03/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENDE 4419 31. Date filed (Month, Day, Year) State FEB 05

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department State of Maryland / Department 23a PtI,25 per me, 25	tment of Health and 1900 02/04/2010 Ticate of Death	d Mental Hyd dhb	giene Reg. No. 2	03160
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See and	/Medic Examir	cal	FELICIA MARIE CHAPMAN PATE  4a. Facility Name (If not institution, give street and number)  4	b. City, Town, or Location of De	January		4:45pm <sup>M</sup>
r* 1	, LAGIIII	101	607 BRIGHTON MANOR DR. APT C.	BALTIMORE		BALTIM	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year   If Under 24 F	Hrs. 8. Date of Birt (Month, Day	h 9. Bir y, Year) Co	thplace (State or Foreign ountry) ARYLAND
	pur ,		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Locat		AIR, ZC	1775	
	Aaryla f sho	5					10d. Inside City Limits 1 □Yes 2 No
	r 28a	Director		ESSEX 10f. Zip Code		10g. Citizen of What Co	
	th with		607 BRIGHTON MANOR DR. APT C.	21221		U.S.A.	,
	er dea tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? es, specify Cuban, Mexican, Pu	' (Specify Yes or No- erto Rican, etc.)		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modral Eventin	ğ	1X Never Married 2 Married 1 Yes 2X No	Yes 2 No Specify:	,	Specify: BL	
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Maryland	d 2 sh Ith and I7 is n traun	i i	· · · · · · · · · · · · · · · · · · ·	ddress (Street and Number or			Zip Code)
<u>6</u>	es 1 and of Health f Item 27 r other t		20a. Method of Disposition 20b. Place of Disposition	erusalem Rd., S	Joppa Md.,	21085 20c. Location - City or	Town, State
<u>=</u>	mit. Pages partment of cortant: If It injury or o		NXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Tabernacle	e_U.MCHR 02-	-05-10	FALLSTON,	MARVIAND
Baltimore,	permit. Pag Department Important: I any injury o			ame and Address of Facility LLIAM C BROWN (		AL HOME-HA	REORD . P . A
	4D = 40		1 July 24 - 321	. 2. PHILA.BLVI	), ABERDEE	N.MD 21001	
	Physician		shock, or heart failure. List only one cause on each line.	and the second s	liac or respiratory ari	rest,	Approximate Interval Between Onset and Death
	/Medical		Due to (or as a consequence of):	UCER			10 month
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POX	leath certific attending p for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	CENT	-	23d. Date of del	ivory
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000		plete			24a. Was a		topsy findings available
<u> </u>	The ate h	Completed			- autops perforr 1 □ Yes	ned? death?	completion of cause of 2 □No
\ \ \	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?  **Yes 9************************************	Othor	eath (Check only on		
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2	endin sath. or; Aft he fun	atio	2 E Flooridont	Mork? 1 ☐ Yes 2 ☐ No		,.,	
IIOISINIO	or Att after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
-			29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, death occupance of examination and/or investigate.	curred at the time, date and pla	ace, and due to the c	ause(s) and manner as	stated.
,	o the lithin 2 or the lo the lo the lo the lo mplet	Medical	one) and manner stated.  29b. Signature and title of certifier //	29c. License number			
	F 3 F 8		10/1/2 100			9d. Date signed (Month	
,	(n)	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print DY . SUBRANANIAN SRINI VAS	- CARTER DELICA	BLYN F	BAITIMONE	MD21229
	1			OI LUCTRAVER		-7-104010	1
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	9			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Rafael Angel Pastran-Borge Feb. 02 2010 5:48A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12943 Twinbrook Pkwy Rockville Montgomery 8. Date of Birth (Month, Day, Year) 09/12/1933 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) . Age (In vrs. last birthday **Funeral** 1 M 2 □ F 578-74-2827 Director 76 Nicaragua Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Funeral Director MD Montgomery Rockville 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12943 Twinbrook Pkwy 20851 USA ral", or items 2 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 2 No 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1∡Yes 2□No SpeciNicaragua SpecifyWhite 'natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Я Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked o traumatic ever ၉ Manuel Ignasio Pastran Maria Evangelina Borge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 i Adela Pastran/Daughter 12943 Twinbrook Pkwy Rockville, MD 20851 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Feb. Daye. Important; If it any injury or o once, 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 2010 22. Name and Address of FaciliRapp Funeral And Cremation Service Signature of Funeral Service Lic MO1585 933 Gist Ave. Silver Srping, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Secure fielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FFMALE: use 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month for Day Month Year signed by the a 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has lirector, page 2 s or Attending Physician: The law autopsy performed<sup>a</sup> 2 🗌 No 1 🗌 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Hospital Other: 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Funeral C the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number ပ္ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Greeks a AUE WHEATON MD FRANSIBO A. MAGE

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB Physician/ ROBERT Year BRIAN POLM 11:10 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE ARBOR HOSPITAL N/A Social Security Number Sex 1 M 2 D F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours June 13,1957 52 Director 216-70-3887 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Brooklyn Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 7th Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Armed Forces?
1 X Yes 2 □ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electronic Supervisor **MDTA** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Edward Polm Margaret Jane Guthrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Jill Polm / Wife 615 Pamela Road Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State February 5, 2010 Maryland Vets. Cem. 4 Donation 5 Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility  $Singleton\ Funeral\ \&\ Cremation$ 100 Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, sician/ REDRATION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DATIC Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury HEPATITIS COHOL the burial-tran and that initiated event resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day 4 ☐ Pregnant 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 page 2 After this certificate funeral director, pag 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🗹 Natural 5 Pending Accident work? 1 ☐ Yes 2 ☐ No death. Investigation a er deat Director the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one)

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Snean Georg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

M.D

32. Registrar's Signature

29c, License numbe

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29d. Date signed (Month, Day, Year)

SOUTH HANDVER STREET BALTIMORE MD 21225

Feb 01,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Februar . Mark Stanlev Plakatoris 2010 3:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson 8. Date of Birth (Month, Day, ) Aug. 23 Social Security Number . Age (In vrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Year) 1927 Months Days Hours Min. 234-32-2852 Director 82 West Virginia Aug. Usual Residence of Decedent shov 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f sh notified a 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 1112 Spalding Drive Unit E 21014 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postmaster U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kostas (nmn) Plakatoris Dora (nmn) Manolakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Plakatoris / Wife 1112 Spalding Drive, Unit E, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremi 3 ☐ Removal from State 4 Donation 5 Differ (Specify) Air Memorial Gdn. 2-5-10 Bel Air, Maryland <sup>22</sup>, Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, 23a. Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aronary antery Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes funeral director, 25. Was case referred to medical To the Hospital or Attending Physician; Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) VO SOL 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar 3 🗌

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AAN VES

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29b. Signature and title of certifier

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31. Date filed (Month,

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Chances

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NORMAN MORTON ROSNER JAN 26 2010 1:39 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 A T Months Days Hours Min. 4/14/1919 1XOXM 2□ F 90 AL 215-16-6383 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 21 No Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7100 Edgevale Street 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Foreign Serv. Federal Government & Elementary/Secondary (0-12) College (1-4or 5+) Budget Officer/Officer State Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolf Rosner Freida Riegel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Rosner, son 496 Mariposa Ave. Moutain View, CA 94041 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Uniformed Serv. Univ. 1/28/2010 Bethesda, MD 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 21. Signature of Funeral Service Licensee MO1539 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital:

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans

Box 68760,

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Division of Vital Records,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other than man.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed

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attending p signed | page 2 should certificate director. this in by the funeral after death

Physician/Medical δ Completed Be Certification: To

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29b. Signature and title of certifier

FEB 05

PETER Z. MCINTYRE

Examine

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 2 🗌 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010° Rana 4:39 AM Jacqueline Medical Aa. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerford Place Columbia Howard 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, December 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral Days Hours Min 1 M 2XXF Months Director Yrs. France 212-40-0423 Usual Residence of Decedent or 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Clarksville Maryland Howard 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code by Funeral U.S.A. 6301 Trotter Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2XX Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Family Business Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ္ Jean Marchal Nicole de Beauregard and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1005-402 Samantha Lane Odenton, Maryland 21113 Christopher Emory 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 2-8-2010 Clarksville, Maryland 4 Donation 5 Other (Specify) St. Louis Church Cemetery Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. art 1. Enter the disea Approximate Interval Between Onset and Death Years recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 X No Pregnant at time of death ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 Tyes 2 No Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ASSISTEU LIVING Other: 2 XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Speci 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pracknoner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) D56531 February 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Pkwy #301 Columbia, Maryland 21045 HarryLi, M.D. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Celts Sparks 12:00 p M 30 2010 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Essex Riverview Nursing Home Baltimore Co. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral ™**M 2□ F Months Days Hours Min. 212-42-8308 Yrs. Director Kentucky 66 28,1943 May Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits iral", or items 23a or 28a-f shov Director Rosedale 1 ☐Yes 2XXVo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7913 Roseland Avenue United States 21237 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 X Married 1 □ Yes 2/□ No Specify. Completed by Specify: 3 Widowed 4 Divorced Year or Dates: White "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier Important: if Item 27 is marked other than any Injury or other traumatic event, the once. Entertainment 11\_Years <u>Musician</u> land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Withrow ဥ Ezra Sparks Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7913 Roseland Ave. Rosedale, Maryland 21237 Madeline O. Sparks (Wife) Baltimore, Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2/3/2010 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee · Config 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** adiopulmonar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary therosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia Chronic Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Coronary artery disease End Stage renal disease performed 1 □Yes 2 ₺No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical 10+1 State Registrar

29b. Signature and title of certifier M.D.

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Surt 204 Parkville MD Jigar. Wortham world 31. Date filed (Month

4 Homicide

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Helen Siatkowski 1 20 AM 0137 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospita bultimo. Bulfmore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) Maryland 1 □ M 2<del>X</del>T Hours (Month, Day, Year) 219-50-6882 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits MD N/A 1 X Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21209 1803 Thornbury Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian , Dorothy Black, White, etc "natural", or 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 ☐xNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic exercises. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Dependent Siatkowski Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryanna Budzik Benjamin Siatkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise G. Jones (Sister) Baltimore, Maryland 21237 1403 Mt. Airy Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2010 Towson, Maryland Service Corp 21. Signature of For eral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk. Maryland Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner eingrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy nerform this certificate completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 W Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend tate of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 Р Mary Jean Schoeffield 3:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3412 Widows Care Fallston Harford If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr. 20 9. Birthplace (State or Foreign Country)
Maryland Funeral 219-22-6247 1 □ M 2 🛛 F Days Hours Min. Yrs **Director** 81 Ĩ928 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the M-dical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 W. Joppa Road 21204 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: Completed 3 X Widowed 4 Divorced Specify white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiers in Important: If item 27 is marked other than any injury or other traumatic event, the Maonee. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emanuel Pokorny Lillian Vojik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Schoeffield 2605 Greene Road; Baldwin, MD 21013 son 20a. Method of Disposition 1 🖾 Burial 2 🗆 Crem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State nation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Gardens! 2/8/10 Timonium, MD 21. Signature of Funeral Le 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CACER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** EBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the attending physician and hed for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Nother (Specify) SON'S home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46988

State Registrar SUITE 102

10WW01

OSLER DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01

COUZI

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:31PM 2010 , Medical INMAR 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 50 Yrs. **Director** NARY/Lanch Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shown any injury or other traumatic event, the Medical Examiner must be notified as any injury or other traumatic event, the Medical Examiner must be notified as 10b. County 10c. City, Town or Location 10d. Inside Cjty Limits Director Baltmore Md 1 🗷 Yes 2 □ No 10g. Citizen of What Country? Funeral 720 N. Calhoun 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) one maker 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname, Mª neill 19a\_Informant's Name/Relationship/Type, Print) Deather 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) onté PAHC PLACE Mallo. Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town State 1 Burial & Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Speci 21. Signature of Funeral Se Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, of heart failure. List only one cause on each line. Approximate mmediate Cause (Final Onset and Death SHOCK Physician SEPTIC disease or condition resulting in death) Medical Examiner I Welk. GASTRIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine been signed by the attending physician and should be detached for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEPATIC CIRRHOSIS 1 Tes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No å 26. Place of Death (Check only one) 2 No Hospital Other: မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FM0969709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATHMORE ST. BATHMORE, MD Evic marcolini MD 2000 W 31. Date filed (Month, Day, Year) State Registrar

**Physician** 

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

S after dec.

seral Director: A seral Director: A seral Director.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):							
ıysıcıan/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 4  Pregnant at time of death 9  Unknown	23d. Date of delivery  Month Day Year				
o Be Completed by Pn	Part II. Other significant conditions of Spiral Steries In June 1 Line Line Line Line Line Line Line Line	23e. Did tobacco use contribute to the cause of death?  1					
	25. Was case referred to medical examiner?  1  Yes 2 No	26. Place of Death (					
cation: I	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	28d. Describe how injury occurred				
Sal Certifi	4 ☐ Homicide determined  29a. Certifier 1 ☐ Certifying Ph	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Nu City or Town, State)  31clan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  31clan: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause					

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral L

29b. Signature and title of certifier

31. Date filed (Mont)

14. Robert Dersether

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BIRSCHBACK NU

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20f6 11:20 PM Jeanne Carolyn Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min June 21, 1922 Mary Land 87 Director 577-20-9467 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 110 Ponytail Lane 21787 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1xx Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) Congressional Staff Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ardis Hunter Emil Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore H. Smith (Brother) 6443 Gerard Court Falls Church, VA 22043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 2-5-2010 Brentwood, Maryland Name and Address of Facility itzke Funeral Homes, 555 Twin Knolls Road Signature of Funeral Service Licens Inc. Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown Month Day Year signed by the be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy page death? 1 🗌 Yes Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp. 27. Mann Leath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending n 24 hours after death. e Funeral Director: Aft pleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed (Chec Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nu actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o Signat 29h nd title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

md 555 South Courter Greet WESTHINGER, 141) 21157 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4c, 10b per doc g900 2-26-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January  $31^{ay}$ 20 fo 6:30 PM Stalnaker Medical 4a. Facility Name (if not institution, give street and number) County of Death Howard Examiner 4b. City, Town, or Location of Death 9365 Spring Water Path Jessup Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea December 22 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 K M 2 🗆 F Days Min. Country) est Virginia Hours Months Director 216-76-1888 50 Yrs West Usual Residence of Decedent 10b. County Howard 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Jessup 1 ☐ Yes 2xx No - Anne Arundol 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9365 Spring Water Path 20794 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Automotive Technician Automobile other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marvin Stalnaker Carol Skidmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Stalnaker (Wife) 9365 Spring Water Path Jessup, Maryland 20794 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Meadowridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2-4-2010 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Witzke Funeral Homes, Inc. any i 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pancreas Physician/ Adrnocarcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant :
☐ Unknown Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by JUANGE LE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 🗌 No 1 ☐ Yes 2 🗙 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) Hospital: 2 No ပ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending Investigation work' 1 ☐ Yes 2 ☐ No Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Franciscoper: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one the dat the time date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30573 2-1-10 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Jon K. Min Ford Columbia 10710 Charter Juite 6020 Dr. 21044 31. Date filed (Month, Day, Year) **State** FEB 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle, Last 2. Date of Death 3. Time of Death Physician/ an Medical 4a. Facility Name (if not institution, give street 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ick Baltimore If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 💢 F Director MD "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MDtimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21229 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 📈 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) y/Seconfi College (1-4 or 5+) umestic omestic Be Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) မ nom pson(Husband) 19b. Mailing Address (Street and Num Batto., ick Jow Rd  $\mathbf{M}$  $\mathbf{D}$  $\infty$ 1 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 12010 rrison torest 21. Signature of Funeral Service Licensee eone Trees 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute disease or condition 10 Medical resulting in death) Due to (or as a consequence of): Examiner 5 Y Conuncy Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to for as a pursuant pour To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending abused on the signed of the signed of the signed by the attendion and the signed of the s To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Kidney 2No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the 29a. Certifier 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2.3.10 1143386 in 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Echow St Ballimore 21201 Itowa 821 Non 31. Date filed (Month, Day, Year) State FEB 05 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month  $P^{M}$ Francis C. . February 3:45 Spence 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 204 St. James Dr. Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 10 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Months Days Hours NC Director 223-32-1392 84 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be Funeral 21061 204 St. James Drive USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Health Aide 12 AACO. Health Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be f Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev 2 Benford Copeland Lelia Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 St. James Drive, Glen Burnie, MD 21061 Beverly S. Zentgraf (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Feb. 2010 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Sign tu a of Funer Service Liv 22. Name and Address of Facility 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the shock, or heart disease, or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Alzheimer Ph\_sician disease or condition Medical resulting in death) Examiner Preumonia Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examiner nding physician and use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atten signed by the atter in the past 12 months?
1 Yes 2 No Day Month Year 1 Yes 2 D P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2. No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 🗌 No 1 🗌 Yes Yes 2 N the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No nours after death.

neral Director: After this or
dilled in by the funeral dire 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2/4/2010 Schuler CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7900 Oak Point Ct Pasadena, MD 21122 31. Date fed (Month, Day, Year) 32. Regig State FEB05 Registrar

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

5601 Loch Raven Boulevard, Baltimore Maryland 21239

Obrawy 10, 2010

10-00934 Carolina Smiglelski

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aio	illia Siniglei	1	1- For State Certificate of Death	Reg.	
	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	Date of Death     Month D	3. Time of Death
Ja	ical Exami		Carolina Katherine Smigielski	February 1,	2010 2338 1118
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County of Death
			Upper Chesapeake Medical Center Bel Air		Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		MM/DD/YYYY) 9. Birthplace (State or Foreign
	Director		338-56-9831 1 M 2 x F 84 Yrs. Months Days Hours	Sep. 15	, 1925 Country Illinois
		ļ	Usual Residence of Decedent	Bep: 13	
	any	H	10a. State 10b. County 10c. City, Town or Location	<u> </u>	10d. Inside City Limits
		l			1 Yes 2 X No
	Maryland 28a-f show d at once.	ţ	Maryland Harford Edgewood  10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?
)	Mary 28a ed at	Director			USA
	h the ? 3a or			( Specify Yes or No-	14. Race - American Indian, Black,
	h wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispatic Original In Was Decedent Original In Was De	uerto Rican, etc.)	White, etc.
	or it	ᆵ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: White
	s afte	þ	or Dates: 16. If a Decement's Usual Occupation (Give kin		6b. Kind of Business/Industry
	hour natu Exan	Completed	15. Decedent's Education (Specify only nignest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	e retired)	
	36 in 72 han "	ple	Never Worked		
	with with giene ner th	E O	17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Last)	Name (First, Middle, Ma	iden Surname)
	filed I Hyg		Joseph Valentine Smigielski Emily	y (unk) Swe	etlik
	D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	o Be	19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number		
	Shou and N 7 is n	To	Deborah K. Smigielski / Niece 487 Winterberry Dr	rive, Edgew	vood, MD 21040
	imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once		20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or Town, State
	of H of H If it		1 Buriat 2 Cremation 3 X Removal from State	2-8-10	DuQuoin, Illinois
	Pag Pag ment tant:				
	Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.	1 3	21. Six ature of Funeral Service Licensee  ATh(LL1) (Luller FSC CP)  222. Name and Address of Facility McComas Funeral 1317 Cokesbury	1 Home, P.	A. gdon, MD 21009
		_	23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care	diac or respiratory arres	st, shock, or heart Approximate Interval
	Physician /Medical		failure List only one cause on each line.		Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)  a Pneumonia complicating atheroscler  Due to (or as a consequence of): disease	otic cardio	JVasculat
			h		
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		]
		盲	cause. Enter Underlying Cause (Disease or injury that initiated		
	d sit	Examiner	(Disease or injury that initiated bue to (or as a consequence of):  Due to (or as a consequence of):		
	sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed a death. etetor: After this certificate has been signed by the attending physician and by the fineral director, page 2 should be detached for use as the burial - transit	a	T UNPENDED 2 Per me 8901 3-25-10 185 10		
	50, te be ex hysician e burial		X UNPENDED 23a, 27, per ME g901 3.19710	TT	23d. Date of delivery
	760, icate be physic the bur	×	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic p	oregnancy	Month Day Year
	687 certifica nding p	cian/I	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		
	Box 6876( he death certificate the attending phy hed for use as the b	\signature	0 1 Yes 2 ✓ No 9 Unknown a Unknown		
	that the dined by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		pacco use contribute to the cause of death?
	P,O es that i	6		1 Yes	2 No 3 Probably 4 ✔ Unknown
	duire	Completed		24a. Was a autops	
	Orc aw re las be 2 sho	=		perfor	med? death?
	Rec The I cate I	ַן לַ		1 V Yes 2	Z NO Tes Z NO
	al Fian:	, e	25. Was case referred to medical		Residence 6 Other.
	of Vital Records, ng Physician: The law requir viter this certificate has been s meral director, page 2 should	B	1 V Yes 2 No		now injury occurred
	of Vital Records, P.O. Jing Physician: The law requires that the Affer this certificate has been signed by fineral director, page 2 should be detach	[	(Month, Day, Year)		
	ion tendi eath.	j.	Natural 5 Pending 1 Pending 2 Accident Investigation		Street and Number or Rural Route Number, City
	Division tal or Attendiins after death.	9	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, S	
<	Dital pital wirs a seral I	Certification	4 Homicide determined (Specify)		e/a) and manner or stated
1)	Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A	<u> </u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the control of th	ce, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
1	o the	1 5	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated  29b. Signature and title of certifier  29c. License number		29d. Date signed (Month, Day, Year)
	H 3 H 5	) ş			February 2, 2010
	7		Hundel Touthall MI)		1 Solidary 2, 2010
		1	30. Name and address of person who completed cause of death (Item 23a)	oro MD 21201	
		T	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltim	OIE, MID Z IZUI	
		Stat			
	Reg	stra	FFR 0 5 2010 Janua S. Jakes		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 2. Date of Death Physician/ Jamuary 2010 5:37 Рм Francis B. Thelen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Good Samaritan Nirsing Home Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, \
-24-1919 1 🛛 M 2 🗆 F Days Hours Min. Year) 90 Director Maryland <u> 213-07-1980</u> Usual Residence of Decedent shov 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director N/A Baltimore 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 3216 Glendale Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Lt. Fire Department Fire Department Be 18. Mother's Name (First, Middle, Maiden Surname)

Mary Chelchowski 17. Father's Name (First, Middle, Last) ည William Thelen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sparks, Maryland 21152 23 Far Corners Mews Lorraine Thelen - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Cemetery 02-04-2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death ONGESTIVE HEART FAILURF Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to jor as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STENOSIS AORTIC 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No Yes 2 1 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

31. Date filed (Month, Day, Year)

LORPAINE

OFORI AWUAH, NO 5430 CABELL BLVD STE 214, BALTIMORE 21236 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 05 2010 Jenus B. parked

D0061789

FEBRUARY, 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 3ay 2010 Year 4:05P Edward Donnelly Tudor Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Balto4b. City, Town, or Location of Death Examiner Towson Gilchrist 6. Sex 1 M 2 F Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Min. Ap 14101th, Pro Y 1927 Days Hours 82 219-10-7341 **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Md. Balto. Perry Hall 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA should be filed within 72 hours after death with 21128 1 Leonard Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 IT Yes, Give Year or Dates,1945-1946 1 ☐ Yes 2 😾 No Specify. If Yes, Give Specify: White 3 🗌 Widowed 4 🗎 Divorced Completed 27 is marked other than "natu traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Balto. Co. Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carrie Lightner Adrian Tudor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Ct. Perry Hall, Md. 21128 Dorothy Tudor Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 2-8-2010 Balto. Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home tol au 21236 9705 Belair Rd. Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician olon disease or condition resulting in death) Caro Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) attending physician and for use as the burial-transi that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death signed by the a 2 🗌 No 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 I To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R1491914 CRNP Estuary 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles 101 Towson MD 21204 Movien Gra 31. Date filed (Month, Day, Year) State FEB 0 5 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b State FI May Oan 2/05/2010 entitled Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1):40A M Mary MOZYT 2010 /Medical a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 11stown Hospice Date of Birth Month, Day, . Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□M 2▼F 12 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla ariment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at MD 1 Nes 2 No **Funeral Director** timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 arview USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Black è 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry joural Secu Elementary/Secondary (0-12) College (1-4or 5+) lerica. Father's Name (First, Middle, Last) Be own send 19b. Mailing Address (Street and Number or Rural Ro Informant's Name/Relationship 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) permit. Page: Department o Important: If i any Injury or once. 3 Removal from State Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final End-Stage Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 2 🗌 No 3 Probably 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Ye/s 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident dear 24 hours a er deal 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2/3/10 W.SKAJAPARSEMID DO057 465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rajupakse, M.D 2835 Smith AV, Suite Baltimore,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 05

10-00898 Fernando Tapp Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 40 AM Physician/ GERTRUDE FLORENCE DEAN THOMPSON Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HAR 8. Date of Birth
(Month, Day, Yer Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 X F Hours Min. Country) Director 062-78-2043 89 1920 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 🗌 Yes 2 🔀 No Maryland Harford <u>Abingdon</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Africa 170 Glen View Terr. 21009 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural", Completed 3 ₩ Widowed 4 □ Divorced Specify. Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beauty Salon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Francis Magnuss Dean Grace (unk) Scotland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arda V. Collins / Daughter 170 Glen View Terr., Abingdon, Maryland 21009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-8-10 Hilltop Service Corp Towson, Maryland Signatura of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ yeu disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to (or as a consequence of) if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown ort II. Other significant conditi contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar			Certific		Death	F	Reg. No.2		03183
	Physicia		DAVID	, Last) RICHARD	TATE				2. Date of Dea Month January	Day	Year 010	3. Time of Death 10:50 M
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	es 1 and of Healt item 2 r other		Barbara Reynold 20a. Method of Disposition		20b. Place of	Disposition ( ery, crematory	Name of	cilliote Av	Date	20c. Location		
imo	Page nent c ant: If ary or		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		1	US MEMO		02-09	-10	BALTIM	ORE, M	IARYLAND
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Fund Service	Drouw	rer	22. Nam WILL 1206	e and Addre EAM C W NOR	ss of Facility BROWN COM TH AVENUE	MUNITY	FUNERA	L HOME	P.A.
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Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome			Ken	al d	`slar	23d. [	l Date of delive	ery
o.	at the death by the attertached for	Physician/N	in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			oic pregnanc r <i>(specify)</i> _	:y			Month	Day Year
σ.	es tha	þ	Part II. Other significant conditio	ns contributing to death bu	ut not resulting	in the underlyi	ng cause giv	en in Part I.	23e. Did t	1 -		ne cause of death?
of Vital Records,	: The law requir cate has been s page 2 should	Completed							24a. Was autop perfo 1 🗆 Yes		b. Were auto prior to co death? 1 ☐Yes	psy findings available mpletion of cause of 2  No
Vita	Physician: The rthis certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			J DOA Oth	_26. Place of Deat				-
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Division	al or Atte s after de al Directo ed in by th	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi			farm, street, fac	ctory, office		28f. Location ( City or To	Street and Nui wn, State)	mber or Rura	al Route Number,
•	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		g Physician: To the best of Examiner: On the basis of and manner sta	f examination a							
Y D	To the Company of the	Z	29b. Signature and title of certifier	an.	we	7	29c. Licens	253	9/	29d. Date sig	3- 2	Day, Year)
			30. Name and address of person	·			oh D-	TOP D 1	Transi D	1 + 3	. 16	1 101000
	Sta	ate	Dr. M. Khan, M. 31. Date filed (Month, Day, Year)	00 0 '-1	1- 0'			ven boure	varu, Da	TUTIHOL	= Mary	1and21239
	Registi	rar	FEB 05	2010 Sekon	v B.	park						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8&18perFH, G900, 2/19/2010, WS State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 8:45 A 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis 402 Forest Beach Road Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth 1929 **Funeral** 1 **№** M 2 □ F Months 029 th. 341928 096-22-5961 80 Director Washington DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Annapolis 1 ☐ Yes 2 🔀 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. ò Completed by Funeral 21409 23a 402 Forest Beach Road items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12, Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Navy Black White etc ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give "natural", 3 Divorced 4 Divorced Year or Dates. Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Aircraft Boating. Designer Be 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Loren Shoots E. Dow Van Dine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21409 402 Forest Beach Road, Annapolis, MD Elizabeth Van Dine/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Ardent Cremation Services 02/04/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Argent Cremation Services 21. Signature of Funeral Service Linensee 7522 Connellery Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): Myo cardi lan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown cate has been sig page 2 should b 1 Yes 2 No Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1000 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or inventioning in my artists that Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director		ocial Security Nu		6. Sex		rs. last birthda	ay) If Und Monti	ler 1 Year ns Days	If Under 2 Hours		ate of Birth 9/20/		9. Birti Foreigi Cou	hplace (State or n untryNew Mexic
w any		Residence of D State 10	Decedent Db. County			City, Town or	Location	tv						10d. Inside City Limits  1 Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.	10e.	Street and Numb	per				10f. Zij		.2		109	. Citizen of Wh		itry?
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2 hours after "natural", al Examiner eted by F	3 [	Widowed  Decedent's Edu  ementary/Secon	cation (Spec	orced If Yes, Give Y or Dates: ify only highest gr College		d) 16a. De	1 Yes 2 cedent's Usua ring most of wo	Occupation	n (Give kin		one	Specify: 16b. Kind of Bu		
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Baltimo permit. Page Department or Important: injury or oft	17	Signature of Fund	las-	Licensee			4112 C	ld Co	lumbi	la Pik	e Ell	icott (	City	mily F.H. , MD 21043 Approximate Interval
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F Vital Rec Physician: The raths certificate and director, page	3 25. \	Was case referre examiner? 1 ✓ Yes 2		Hospital: 1	Inpatient 2	2 ER/Outp	patient 3		`	heck only or Nursing Hom	<u> </u>	Residence 6	✓ Other	: Scene
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1 ledical Certificatic		Homicide	deter	d not be mined (Special	ý)		n, street, factor			0	r Town, St	ate)		ral Route Number, City
To the Hos within 24 h To the Fur completely	one)		ledical Exa	miner:On the bas and manne	s of examinati		estigation, in n		death occu				due to th	e cause(s)
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		Theodore M.		1111	tant Medic		er 111 F	enn Stre	et, Balti	more, MI	21201			
State	24 1	Date filed (Month	Day Veres	20	Registrar's Sig	anature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 29, January 2010 05:03 A M Effie Venetos /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🕱 F Months Days Dec16,1926 Greece Director 219-58-3176 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2 No Harford Director Md. Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 823 Flintlock Drive 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk) Lambrinos Efrosine Lambros 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mario Venetos / Son 823 Flintlock Drive BelAir, Md. 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Febr<sup>Date</sup>ary 1 Burial 2 Cremation 3 Removal from State Greek Orthodox Cem 2, 2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): I wo willy Examiner As ping hou Secupatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Resistant organisms 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐Yes 2 ☐No 1 □ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O.

28a-f show

permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan bepartment of Health and Mental Hygiene. It is the market of the than "ratural", or items 23a or 28a-f show Important: It item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or other traumatic event, Its. Medical Exemples must be a cultical at

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Division of Vital Records,

certificate be Vithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dil the Hospital or Attending hin 24 hours after death.

> State Registrar

Medical

31. Date filed (Month,

29b. Signature and title of certific

29a. Certifier

Christopher 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0066220

29d. Date signed (Month, Day, Year)

2910

DHMH 17 Rev 1/2001

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1	Examir	ner	4a. Facility Name (If not institution, gi	0	D 0000		or Location of Deatl	1	4c. County of Dea	th
			5. Social Security Number 6.		VD PARK	- /	r If Under 24 Hrs.	D. D. A. A. Dist.		
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	Director		Usual Residence of Decedent		91	1		12-12-	1928	MS
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	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show he Medical Examiner must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent				pacify Yas or No-	14. Race - Ame	erican Indian.
	Hen diner	-un	1 Never Married 2 Married	Armed Forces?	No.	If Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black, Whit	
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Vis	or Attendater deatl Director: in by the	iflo	3 Suicide 6 Could not to determined	208. Flace UI IIII	ury - At home, farm, st	reet, factory, office		28f. Location (Str.	eet and Number or R	ural Route Number,
Ö	al or A safter I Direct d in by	Certification:	4   Homicide	building, et	c. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge, dea	h occurred at the t	time, date and place	, and due to the ca	use(s) and manner as	stated.
	e Ho 1 24 le letel	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examination and/or ir	vestigation, in my	opinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
	roth withir roth	M	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mont	h, Day, Year)
					MD	D	31464		211/11	)
•			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)				
1			SHOALB A. HA	Pitoni AA	17 87 1 1	FUTAN	1 St Smi	T TAC	124171 mov	= MD 21201
1	Sta	te		32. Registr	ar's Signature	0-(11)00	, -1 -VIC	- 200	1710 0 (11110)	- 11/-1-01
	Registr		31. Date filed (Month, Day, Year) FER 0 5	2010 Sen	wa S. x	parke				E MD 21201

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1050 AM Dorothy Wright Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8 Date of Rirth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 1 🗆 M 2 💢 F Director 219-32-8408 78 N.C. -17-1931 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MD Baltimore 1X Yes 2 No na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21218 316 E. 28th Street USA items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes XIXNo Specify: Black Specify: "natural", Completed 3 Nidowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) Loudon Fog Seamstress 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mattie Lewis Harry Demery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaWon Ellis-Niece Saddlestone Ct Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place)
King Memorial Pk 2-8-2010 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mila 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) consequence of): **Examiner** Sequentially list conditions, Examine If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant Dav Year

Completed by Be မ Certificate:

page

completed filled in by

Medical

Division of Vital

1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death g ☐ Unknown	5 Other (specify)
art II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part

	23e. Did tobacco us	se contribute to the cause of death?
	1 ☐ Yes 2 🖟	No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
7	lly one)	

	24a. Was an autopsy performed? 1 ☐ Yes 2 16	
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence	6 ☐ Other (Specify)
1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation M	Injury at work? 1  Yes 2 No	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	ffice 28f. Location (Street a City or Town, State	nd Number or Rural Route Number, le)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the	time, date and place, and due to the cause(s)	and manner as stated.

29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my knowledge, death occ only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, dea	ation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner sta
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Heyn M.D.	AT 2438946	02/01/200

30. Na

			0100110		/ - 1/	
me and address of perso	on who completed cause of de	ath (Item 23a) (Type, Print)				
AFrey P	epin, M.D	- Union Mer	norial Hose	rital B	altim	are, MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Watters 2010 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Midital Baltimore VA Center Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Country) 08/02/1929 **Director** 80 219-10-4243 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location at 10d. Inside City Limits filed within 72 hours after death with the Maryland Director or 28a-f sh notified a N/A 1 X Yes 2 No MD Baltimore 10e. Street and Numbe 10f. Zip Code þ 10g. Citizen of What Country? "natural", or items 23a o Funeral 1319 Windemere Avenue 21218 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 19 Black White etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Black er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Med once. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Driver <u>Distribution</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Watters Victor Luella Benns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles F. Watters, Jr., Son 4214 Hazel Avenue, Baltimore, MD 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 02/10/2010 4 Donation 5 Other (Specify) Garrison Forest Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Justate Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes 2 ☐ No 2 N Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗆 Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit ALL4176435 L14740

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

James 31. Date filed (Month, Day, Year) 02/02/2010

MI) 21201

Bultimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, per Fh g900 2/23/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month JANUAR Physician/ 2010 21:52 Medical 4a. Facility Name (if not institution, give street and numb 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samonitan Hospiton Social Security Numl@293 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** N. Carolina Days 1 X M 2 □ F Hours Yrs Director show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT\_use retired) (Specify only highest grade completed) ecopday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b Place of Disposition (Name of cemetery, crematory or other Burial 2 Cremation 3 Removal from State 5 Other (Specify) pate re of Juneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) infiltrates Bilateral / Wing Pnysician/ Medical Due to (or as a consequence of): Examiner PSIS Samentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): 68760 \* signed by the attending plants as the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 ☑ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Matural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year, Mah 12010 ES 01/31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samar, tain Wospital 5601 Loch Raven Blvd, Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

SAMONI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 614 P Ware Fe 2010 03 /Medical 4c. County of Death ution, give street and number Examiner genera umbia Howa (In yrs last birthday) 64 Yrs. Date of Birth (Month, Day, If Under 1 Year | If Under 24 h (State or Foreign **Funeral** Hours Months Days 1 □ M 2 🗙 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, In a Medical Examiner must be notified at Ellicott 1 □Yes 2 🔭o **Funeral Director** Howard 10g. Citizen of What Country? 10f. Zin Code USA carlet Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Completed cedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working lift. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) oordina Tor 18. Mother's Name (First, Middle, Maiden Surname r's Name (First, Middle, Last, Be ۵ Rural Route Number. permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau once. 21042 War 20a. Method of Disposition 20b. Place of Disposition cemetery, erematory 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signa of Funeral Service Licensee 23a. Part 1. Enter the hisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trans and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) s been signed by the s should be detached to 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ acute differ 80 tic Shock 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed encophalopa - acute 24b. Were autopsy findings available prior to completion of cause of death? cena ONOXIC 24a. Was an After this certificate has I autopsy performed? myocardial infove subalachno, hemopphay 1 □Yes 2 ⊡No 1 ☐ Yes 2 19 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 □ No 2 Accident investigation after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 165 00066515 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wat 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 1226 KM Physician Woods arroll anuan 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Northidest Baltimore Hospital Kandalls toiUnl 8. Date of Birth (Month, Day, Year)
Dec. 23,1939 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 212-36-8691 70 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemples must be rollified at MD Baltimore Randallstown 1 □Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 9077 Meadow Heights Road 21133 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic events. filed within Elementary/Secondary (0-12) College (1-4or 5+) N/A Owner/Operator Cab Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Cianci George W. Woods ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woods/Wife 9077 Marion Meadow Heights RD. Randallstown, MD. 21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park Feb. 5.2010 Sykesville, Maryland □ Donation 5 □ Other (Specify) 21. Signature | Funeral Service Licen Jee AMBROSE FUNERAL HOME, INC. 328 Sulphur Spring RD. Arbutus, MD. 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 7 hours **Physician** MUDOVOLIMIC disease or condition resulting in death) /Medical Due to ( Ja consequence of): Examiner WED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown POPLUSE Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 s has autopsy performe After this certificate 1 ☐Yes 2 ☐No 1 ∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? 1⊠Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After **≯** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide

Baltimore, Maryland 21215-0036

Box 68760.

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9

Division of Vital Records,

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of/certifier

101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Old

orist

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HOO68505

29d. Date signed (Month, Day, Year)

andan

31, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 2 0 1 0 0 2 1 0 2									
			Registrar  1. Decedent's Name (First, Middle,	Last)	Cei	uncate of b	Catif	2. Date of Death	g. No. 2	3. Time of Death		
	Physicia Medic		George	M. V	Villiams			Februar	y <sup>D</sup> Y, 20 <b>Y</b> O	4:50 А м		
	Examin		4a. Facility Name (if not institution, Baltimore Washi		Center	4b. City, Town, or Glen B	Location of Death urnie		4c. County of Dea Anne Art			
	Funeral Director		5. Social Security Number 233-56-4944	5. Sex 1 A M 2 F	(In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth March, Day, Y March 2	9. Bir (ear) Co 2, 1938 We	thplace (State or Foreign buntry) SST Virginia		
	nd how at	۲	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	/anyla 8a-f s tified	Funeral Director	Md. Anne	Arundel	Glen	Burnie				1 ☐ Yes 2 💆 No		
	a or 2 be no		10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?		
	h with	ler.	1602 Manning Ro				061		USA			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show ir other traumatic event, the Medical Examiner must be notified at	ρ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Marri</li><li>3 ☐ Widowed 4 ☐ Divorced</li></ul>	12. Was Decedent E Armed Forces? 1 🖾 Yes 2 🗀 I If Yes, Give Year or Dates.	No.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🖾 No	n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W]			
5-0	2 hour	plet	15. Deceden (Specify only higher		6b. Kind of Business	Industry						
121	ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	y/Seconday (0-12) College (1-4 or 5+)   life. DO NOT use retired)  8th Truck Driver Tractor T								
d 2	illed w Il Hygi I othe vent, i	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)										
ylar	should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	잍	Citate II. Williams									
Maryland	shou h and 7 is m traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Barbara J. Williams (Spouse) 1602 Manning Rd. Glen Burnie, Md. 2106										
re,	I and it Healt item 2		Barbara J. Wil 20a. Method of Disposition	liams (Spous	20b. Place of Dispo	sition (Name of			Md. 21061 Oc. Location - City or	Town, State		
mo	Page 1 rent of int: If i		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S			matory or other place ematory In		10	Baltimore,	Maryland		
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Servic Li	envie				-	uneral Hom Md. 21122			
			23a. Part 1. Enter the disease, or shock, or heart falure. List of	complications that caused by one cause on each line	the death. Do not ent	er the mode of dying	g, such as cardiac o	r respiratory arrest	t,	Approximate Interval Between		
N.	nysician/		Immediate Cause (Final disease or condition resulting in death)	_ a	Corona	> Arter	~ Did	Rose		Onset and Death		
7	Medical Examiner	Examiner Duchtes										
		iner	Sequentially list conditions if any, leading to immediate	Due to (or as a		_						
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c		with						
_	cate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a	consequence of):							
	icate t g phys is the l	ledical		d								
. Box 68760	Attending Physician: The law requires that the death certifica re death are death are death extrement. After this certificate has been signed by the attending poy the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ Pregnant at 9 ☐ Unknown	у		23d. Date of de Month					
ls, P.O.	v requires that the speen signed by should be deta		Part II. Other significant conditio	ns contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.		tobacco use contribute to the cause of death?  Yes 2 \( \text{No} \) No 3 \( \text{Probably} \) Probably 4 \( \text{Vunknown} \)			
Division of Vital Records,	ician: The law rec certificate has bee rector, page 2 sho	Completed by						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of		
ta	ysician: is certific director,	æ	25. Was case referred to medical examiner?	Hospital:		Otho	ace of Death (Check	only one)				
of Vi	r this eral dir	년 :	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatie	ent 2 ER/Outpatie y 28b. Time o	nt 3 X DOA	4 ☐ Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Other (Spec	cify)		
o uc	utending Phideath.	icat	Natural 5 Pending 2 Accident Investig		(Year) injury	work'	? Yes 2 □ No		injury socialisa			
Division	a Figure	Certificate:	3 Suicide 6 Could r 4 Homicide determi		ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,		
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director completed filled in by the	Medical	(Check 2 Medical E	Physician: To the best of raminer: On the basis of ex Nurse Practioner: To the basis	camination and/or inves	tigation, in my opinio	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.		
_	Vithi To th		29b. Signature and title of certifier			29c. License	_	29	d. Date signed (Mont	h, Day, Year)		
	)		30, Name and address of person v	ho completed cause of do	eath (Item 23a) /Time		8686		2-1-1			
			31. Date filed (Month, Day, Year)	Plann	1509	Rutshi	e this	hvas	Andl	NO 21012		
	Stat Registra		FFR 0 5		r's Signature	and						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 15, Physician/ George L. Andracsek 4:20 A 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary Hospital Leonardtown St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**√**√M 2 □ F Days Hours (Month, Day, Year ug 28. 1 Washington 579 44 8846 75 934 Director Aug Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: if item 27 is marked outher than "natural", or items 23a or 28a-f show ant: if item 27 is marked outher than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Prince George Clinton 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 6809 Fulford Street 20735 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status vvas Decedent Ever in U.S. Armed Forces? 1  $\square$  Yes 2  $\square$  No If Yes, Give 52-1960 Year or Dates. 14 Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 XX Specify: Specify: Completed 3 V Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baker University Pastry Shor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Andracsek ည Rosalie Straub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Chris Andracsek 5999 Autumn Spell, Elkridge, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1/20/2010 1 XX Burial 2 Cremation 3 Removal from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Lice N01222 Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final vocardial Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Kours Sequentially flet conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav Year signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISCASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy 2 🗆 No 2 100 1 TYes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work?
1 Yes 2 No iniury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 1 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29g. License number 1. 15 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonardtown md 20650 Allen St. Marus Hospi 31. Date filed (Month, AN 220 2010

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20 10 6:30 A Katherine Z. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BERLIN NURSING & REHABILITATION CTR WORCESTER BERLIN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. (Month, Day, Year, **Director** 100 221-14-7802 Dec. 11, 1909 Wilmington, DE Usual Residence of Decedent 10a. State 10b. County Ħ 10c. City. Town or Location Director 10d. Inside City Limits or 28a-f st notified 1 Yes 2 X No Worcester MD Berlin 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o with Funeral 9715 Healthway Drive USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? Ves 2 No 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married verzo, Katherine 9, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: white Specify 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working rtal Hygiene. ed other than " event, the Mer life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) New York University registrar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ Albert Zuelke Emma Zimmerman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon Brett Alverzo 10601 Pine Needle Rd. Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Mem. Gardens Jan. 28, 2010 Broomall, PA 22. Name and Address of Facility
McCrery Funeral Homes, Inc. 3924 Concord Pike 21. Signatu ma of Fun re I S Wilmington, DE 19803

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immedit cause. Enter Underlying Cause (Disease or iinjury Jule to for as a consecuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tes 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 3 
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 📉 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur

State Registrar 9715 HEALTHWAY DRIVE,

BERLIN,

MARYLAND 21811

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP,

PENNIE SAVAGE,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dennis R. Burchell January 2dfh 03:00 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1209 Juniper Road Shady Side 5. Social Security Numbe 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 0771971949 Pennsylvania Director 60 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Shady Side Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be 20764 Funeral 1209 Juniper Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Construction Manager Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If item 27 is marked other th, any injury or other traumatic event, the <u>once.</u> Construction 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norma Matulis Robert Burchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Talbott/Daughter 1213 Gwynne Ave. Churchton, MD, 20733 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Kalas Crematory 1/23/2010 4 ☐ Donation 5 ☐ Other (Specify) Edgewater.MD 22. Name and Address of Facility George P. 2973 Solomons Island Road, 21. Signature of Funeral Service License Kalas Funeral Home ala 2973 Solomons Edgewater. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CANCER months Medical Examiner HECOMS Cigarette Smak Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Year Pregnant at time of death Day 1 Yes 2 9 Unknown should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 Hospital or Attending Physician: The performed' 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director. At completed filled in by the fu Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3169 Braverton St. # Ohen

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Carlyle Burchill Robert 2010 9:20 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Tranquility at Frederick Fredericktowne Frederick Frederick If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Michigan Hours (Month, Day, ) Months Days Min 86 Director 1923 362-26-9014 Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 XYes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2503 Catoctin Court 21702 United States ?7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 KM Arried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify. 3 Widowed 4 Divorced Completed White Year or Dates. 1941-83 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Antique Auto Parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည Robert Stanley Burchill Elna Sundstrom and lis ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Harriett H. Burchill/wife 2503 Catoctin Court Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once, 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Final Journey Crematory 1/22/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville 21. Signature of Funeral Service Licens noman M00957 23a. Part 1\( \frac{1}{2}\) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Jacks Vaccular Departe Immediate Cause (Final disease or condition Onset and Death heroscles onc Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any leaving to immediate cause. Enter Underlying Examiner Due to lor as a considuence of burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the buri Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No st. Living ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0035152 MO Frederik, MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 MO Thai Tohuson

DHMH 17 Rev 7/2009

Registrar

KranR

egistrar's Signature

			Please Amend 1 = State Registrar	Type or Prin #25, 27,28 State of Mar Item 23a P	t in Blac Ba-f pe Vland / D tI per	k Indelik r ME g eparime me g90 Certifica	ole Ink. 901 37 nt of 17 1 037 te of D	Ensure A /12/10 T7 ealt/2010d leath	Viental Hy	s Are l giene Reg. No.	_egible. 2010	03198
	Physici /Medic		1. Decedent's Name (First, Middle, Las Charles	M.			wn	Location of Death	2. Date of De Month	Day	Year 12 201 County of Deat	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give  The Johns Hopkins H  5. Social Security Number 6. S	ospital	(In yrs. last birth	Balt	imore	City If Under 24 Hrs.	8. Date of Bir			hplace (State or Foreign
	Funeral Director		287-12-5837 Usual Residence of Decedent	<b>X</b> M 2 □ F	92 Y	rs. Months	Days	Hours Min.	8. Date of Bir (Month, Da September	er 4, 1	1917 OH	(10)
	ne Marylan <b>:8a-f</b> s <b>how</b> tiffied at	ector	Maryland Howard		Columbia	1				40 - 0'4'-	of What Co	10d. Inside City Limits 1 Yes 2 X No
	eath with the same or 2 and 2	Funeral Director	10e. Street and Number 6417 Allview Drive 11. Marital Status	12. Was Decedent Ev	er in U.S.	2	ip-Code 21046 edent of His	spanic Origin? (Sp	pecify Yes or No	USA	en of What Co	
036	urs after dans, or iten	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 √z Yes 2 □ No If Æes, Give Year or Dates: 42		If Yes, sp 1 ☐ Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify:	white
21215-0036	flied within 72 hours after death with the Maryland Hygien ther than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			life. DO NOT	vork done d	luring most of wor	king		id of Business/ ernment	Industry
	S de la Se	To Be Co	17. Father's Name (First, Middle, Last)  Charles W. Brown		. Н	шу		18. Mother's Nan		, <i>Maide</i> n		
Maryland	and 2 should ealth and   en n 27 is merke ier traumatic		19a. Informant's Name/Relationship ( Gayle Hill- daughte	,				and Number or Ru O, Columbia			Town, State, Z	?ip Code)
Baltimore,	Pages 1 and of Herant: If item	II)	20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		20b. Place of cemeter.  Arling	ton Natio	ona1Cen	netery 10	Date 11 2010		ation - City or	
Balt	permit. Departn Importa any inju		21. Signature of Furieral Service Licen  A  23a. Part 1. Enter the discase, or com	10/234		Fleck 7601 S	and Addres Funeral andv. St	s of Facility  L Home, INCoring Rd	Laurel. 1	MD 2070	07	Approximate
ME	Physician /Medical Examiner	J.	shock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a. Sundur Due to (or as	1 /	emor	1	ge_			and mo	Interval Between Onset and Death
fox 401 68760,	ss that the death certificate be executed gned by the attending physician and be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CERTIFICATION APPROVED BY MEDICAL EXAMINER								
D. Box 68	ne death certific the attending p ched for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 ☐ Ectopio 5 ☐ Other (		1		2	3d. Date of de Month	livery Day Year
23. P. P.	w requires that the bear signed by she uld be detail	by	Part II. Other significant conditions of	ng cause giv	ven in Part I.	23e. Did 1 🗆		_	o the cause of death?			
Beco⊒	The law req ate has been page 2 shru	Completed							24a. Was auto perfe 1  Yes		prior to death?	utopsy findings available completion of cause of
of Vita	fing Physician The lav n. After this certificate has I funeral directo, page 2	To Be	25. Was case referred to medical examiner? 1 XYes	Hospital: 1 Mnpatient		·		1 <u> </u>	ome 5 Res	idence 6		cify)
五 Division of Vital Reco	or Attendater death	Certification:	27. Manner of Death  1 Natural 2 Naccident 3 Suicide 4 Homicide  5 Pending investigatio 6 Could not be determined	28e. Place of injury building, etc.	year) unk y - At home, far (Specify)	m, street, facto	ory, office	?? Yes 2[ <b>X</b> No	City or To	t fel (Street and wn, State)	.1 d Number or R	tural Route Number,
	To the Hospital within 24 hours a within 24 hours or To the Funeral I completely filled	Medical (	29a. Certifier (check only one)	nysician: To the best of miner: On the basis of e and manner state	examination and	death occurred/or investigati	ed at the tin ion, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) e, date and	and manner a place, and du	s stated. ue to the cause(s)
	1	Me	29b. Signature and title of certifier	rong	•		0 00	69625	5	29d. Date	e signed (Mont	th, Day, Year) 2, 2010
	1cx1		Wei Xion	completed cause of de		(Type, Print)		600	North We	olfe St	, Baltim	ore, MD, 21287
	Sta Regist	ate	31. Date filed (Month, Day, Year)  JAN 2 1 201	32. Registrar	s signature	boules						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 215 000 GOSU1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Anne Arundel Harwood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) MD 1 M 2XXF Months Days Hours Min. 215-28-9925 *#1257*4930 Director 79 Yrs Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 570 Bellervive Rd. Apt. 231 21409 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. by ☐ Yes 2 🔀 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give 3XXWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Floyd Sheckells Anna Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Braswell Daughter 619 Riden St. Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hillcrest Cemetery 1/18/2010 | Annapolis, MD 22. Name and Address of FacilityHardesty Funeral Home, P.A. 21. Signature of Ean Service Lice 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancir Pnysician/ disease or condition resulting in death) 20 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death signed by the a g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s autopsy performed? Yes 2 N 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) director æ examiner? 050100 2 1 No Other 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signaty e and title of certific 29d, Date signed (Month, Day, Year) 065272 118/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dringitis Besta MO 21401 DU 0.000 31. Date filed (Month. 32. Registrar's Signature State park Registrar

DHMH 17 Rev 7/2009

10-00601 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Duane Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Dav Month **Medical Examiner** Duane Earl Brown January 20, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's **Funeral** 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Director Hours Min Jan. 5,1953 579 70 0296 Country) WashDC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f show e notified at once. 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified as once MD Prince <u>George:</u> Clinton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4929 Plata Street 20735 Funera 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. Yes 3 Widowed 4 X Divorced If Yes, Give Year Yes 2X No specify. Specify. Black 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Fork Lift Operator Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Brown Be Alice Clark 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Cooley/fiancee 4929 Plata Street Clinton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Park 1-28-10 Baltimore, MD 4 Donation 5 Other Specify Signature of Funeral Service License 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington RD Waldorf, Physician Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED cate has been signed by the attending physician page 2 should be detached for use as the burial AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed<sup>2</sup> death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other; Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi

28a. Date of Injury (Month, Day, Year) Certification 1 V Natural Pending 1 Yes 2 No filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide Homicide 29a Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 21, 2010 30 Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Markh, Dax, Year). 32 Registrar's Signatur Registra

1910 hrs

Death

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 au **Physician** January 21, 9:35 A<sup>M</sup> Myrtle Irene Bines /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Dowe11 588 Twin Cove Lane Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 15, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🖾 F 1934 May 75 Mary land Director 219-30-4097 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Its Medical Examinar must be notified at 1 ☐ Yes 2 📉 No Director Volusia Edgewater Florida 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 32141 815 Egret Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2천 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 忆 No Specify: White þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) 12 College (1-4or 5+) Telephone Operator Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Knox Edward Connor ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 588 Twin Cove Lane, Dowell, MD 20629 Veronica Miskowski / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 B Cremation 3 ☐ Removal from State 1/21/2010 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service License michael ? P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARCINOMA OF BREAST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical as attending plant for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ▼ No 9 ☐ Unknown Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ESSENTIAL HYPERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 A Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital 29a, Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centifier January 21, 2010 D0067788 Tell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drw 10 14090 H.G. Trueman Road, Suite 2300, Solomons, Maryland 20688 Leena Rao Kodali,

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrars Signature

knews

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Physician/ 7837 AM Martin Kenneth onun 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number if Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days July 4, 1925 Hours Director Pennsylvania 84 578-38-8152 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2X No Maryland Prince George's New Carrollton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7712 Topton Street 20784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 

✓ Yes 2 

No Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 1943-46 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electrician Electronics Be and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martin Luther Boyer Mabel Weyandt Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joycelyn S. Boyer/wife 7712 Topton Street New Carrollton, Maryland 20784 Important: If item 27 any injury or other tronce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ament of H 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Final Journey Crematory 1/20/2010 Woodbine, Maryland 21. Sign v re of Funeral Service Licensee Coung Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M. M00957 MD 21029 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suito 222 Gallant Fox Lase 31. Date filed (Month Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 01/18/2010 Year 12:09 pm **Physician** Randolph Brown /Medical Anne Arundel 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harwood 4750 D Flanders Lane If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Months 1**⊠** M 2□ F 03/17/1939 Director 215-46-1458 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State other traumatic event, the Medical Examinar must be notified at 1 Tyes 2 No Anne Arundel Harwood Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or Items 23e or ury or other traumatic event, Ira Madical Exarting trinkel to U.S.A. 4750 D Flanders Lane 20776 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Johnson 2 John Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4750 D Flanders Lane, Harwood, MD 20776 Cathy Brown/Thomas (daughter) 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 01/21/2010 Clinton, MD permit. Page Department of Important: If any injury or once. Lee Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityLee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licensee 8125 Southern Md Blvd., Owings, MD 20736 Lisa M **Mount**e 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SMWHS Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA P 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed the burial-transit Box 68760, USB ò Records, P.O. the signed by has Division of Vital Hospital or Attending Physician: this after death. 24 hours a

28a-1 show

Baltimore, Maryland 21215-0036

3 🗍 Suicide 4 | Homicide 29a. Certifier

Medical

State

Registrar

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Sign

determined

Pate signed (Month, Day, Year)

of death (Item 23a) (Type, Print) 30. Name and address of pe 900

32. Registra s Signature 2010

DHMH 17 Rev 1/2001

within 2

Yer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Richard 20% Craig Chesbro January 6:58 p.m.<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York **Funeral** Days 1 X M 2 □ F Hours 10/20/1942072-36-6135 Director 67 Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 10a. State 10b County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21970 Stoney Brook Drive 20653 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Gilbert Chesbro Flora Jacob Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21970 Stoney Brook Drive, Lexington Park, MD 20653 Christopher Chesbro/Son tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 01/22/2010 | Lexington Park, MD 21. Signature of Puneral Service Licens

Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician andromyo disease or condition Medical resulting in death) Due to (or as a consequen of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Xes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospice 2 000 မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1XX Natural 5 Pending n 24 hours after death.

Funeral Director: After the function of the function 1 ☐ Yes 2 ☐ No Accident Investigation М 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

Jennifer/Schmidt,

30. Name and address g

31. Date filed (Month, Day, Year) 32. Rehistrar's Signature JAN 25

D.O.

erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Hey 7/2009

H0055751

40900 Merchants Lane, Suite 205, Leonardtown, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ MANUARY THOMAS L. CLARK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND EARE ERRY PEE HEAL If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number If Under 1 Year **Funeral** Days 1 🕅 M 2 🗆 F 71 SEPT MARYLAND Director 218-34-1509 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1X☐ Yes 2 ☐ No MARYLAND **HARFORD** HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 108 WIDGEON DRIVE 21078 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 1957-63 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ASSEMBLY WORKER **AUTO MANUFACTURE** 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည HEZEKIAH CLARK MILDRED ELIZABETH JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THERESA TIMS / DAUGHTER 309 TIDEWATER DRIVE, HAVRE DE GRACE, MD 21078 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET. CEM. 01/29/10 CROWNSVILLE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility

LISA SCOTT FUNERAL HOME, 552 LEWIS STREET 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on EAREINOMA Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to himse liate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a nonsequer on or) ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗷 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

(Check

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0726921

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10-00604 Karenlee Curvin

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certifi	cate of	Death			Reg. No.	2010	0320
Physici ledical Exami		1. Decedent's Name (First, Middle Karenlee	,Last)	Curvi	in			2. Date of E Month January	Death Day 7 20, 201	Year 10	3. Time of Death 2150 hrs
		4a. Facility Name (if not institution 410 Denison Street	ı, give street and number)		4	b. City, Town, or Baltimore	Location of			. County of Death	1
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last b	irthday)	If Under 1 Year			Birth (MM/I	DD/YYYY) 9. Birl Foreig	
Director		575-66-5260	1 M 2 X F	56	Yrs.	Months Days	Hours	Min. Apr.	17,	1953	untry) Texas
any		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location	on					10d. Inside City Limits
* ·	Ļ	MD		Balt	imore						1 X Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
h the N 3a or		410 Denison S	Street			2	1229			U	SA
ath wit tems 2 st be n	Funeral	11. Marital Status  1 Never Married 2 Ma	12. Was Decedent Armed Forces?					n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ White, etc.	can Indian, Black,
her de: ", or i			1 Yes 2	X No	1	Yes 2 X No	specify:			Specify:	White
ours a	15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Bu								Kind of Business/I	ndustry	
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MD 2' d 2 should th and Mi n 27 is ms	J.	19a. Informant's Name/Relationsh  Jason Curvin		1.2		Address (Street Ottowa I		per or Rural Route N			Zip Code)
e, MD 2 I and 2 shou Health and N item 27 is n		20a. Method of Disposition		20b. Place	of Disposit	ion (Name of cerr		Lusby, Jan 23		20657 Location - City or	Town, State
P = = = =		1 Burial 2 X Cremation 4 Donation 5 Other Spe			atory or othe Cremat			Jan 23 2010	C1	linton, 1	MD 20735
Baltimo permit. Pag Department Important; injury or of		21. Signature of Funeral Service L		1200			of Facility	Lee Fune			
		Gonz J. Goff	/		812	25 South	ern M	aryland E	Blvd.	Owings	, MD 20736
Physician /M di I		23a Part I. Enter the disease, or of failure. List only one cause of	on each line.								Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertens  Due to (or as a conse		nerosc	lerotic	card	10Vascu1a	rals	sease	Deau
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С								
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760, icate by physic the bur		IF FEMALE:	23c. If yes, outcom	e of pregnance	у	., g900 .	2/24/	10 11	23d.	. Date of delivery	
Sox 687 leath certific e attending p	sician	23b. Was decedent pregnant in the past 12 months?	4 Pregnant at t	me of death	- =	Ideath 3 <u> </u> er (S <i>pecify)</i>	Ectopic p	oregnancy	'	Month D	ay Year
Box ne death c the atten ted for us	Physi	1 Yes 2 No 9 V Unkr	9 Olikilowii								
lecords, P.O. Box 68' The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	by P	Part II. Other significant condition  Chronic alcoholic		but not resulti	ng in the un	derlying cause gi	ven in Part				he cause of death?  ably 4  Unknown
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of Vital Records, ing Physician: The law require Net this certificate has been siminared director, page 2 should be a should b	Completed					<del></del>		pe	formed?	death?	ompletion of cause of
DZ C .0 P.	ادہ	25. Was case referred to medical						Check only one)	s 2 No	1 Yes	s 2 No
Vita hysicia this ce	TO B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/C	Dutpatient	3 DOA	Other _	Nursing Home 5	Residen	ice 6 🗸 Other:	Scene
n of Vital   ding Physician: h. After this certif funeral director.		27. Manner of Death  1 X Natural 5 Pendii	28a. Date of Injur (Month, Day,Ye	y 28b.	. Time of Inj		at Work?	28d. Describ	e how injur	y occurred	
Division tal or Attendi rs after death. al Director: Act in by the fr	icati	2 Accident Invest	igation 28e Place of Init	ury - At home.	farm, street,				(Street an	nd Number or Rur	al Route Number, City
Divisio Hospital or Atter 24 hours after deat Funeral Director	Certification:	Suicide 6 Could determ	not be		,	,,	g,	or Town			arreate names, eny
hin the	Medical C		/sician: To the best of my niner: On the basis of exam								
To wit Con	Mec	29b. Signature and title of certifier	and manner stated.			29c. License	number	OCME	29d. D	ate signed (Moni	th, Day, Year)
		Theodore W	1. Kind:	Ta.	Tu	O.C.N	1.E.	OGME	Janu	ary 21, 2010	
		30. Name and address of person w Theodore M. King, Jr.,		,	niner 1	11 Pann Stra	et Ralti	imore, MD 212	01		
St	ate	31 Date filed (Month, Day, Year)	32. Registrar				or, Daill	THOIS, WID 212			
Regist		JAN 2 7	2010 Deneu	N B.	par	Mad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Terrance S. Davy Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Med. Ctr Allegany Cumber land **Funeral** Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 □ Months Days Hours (Month, Day, Year, Director 38 217-86-3181 May 16.1971 Cumberland, MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Mineral 1 🗌 Yes 2 🔀 No Keyser 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Rt. 6, Box 6010 26726 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 0 Black, White, etc. 2 pe 1 and 2 should be filed within 72 hours after tof Health and Mental Hygiene.

If item 27 is marked other than "natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Phone Operator Telemarketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert L. Davy Ann V. Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 a Department of Health Important: If item 27 any injury or other tra Dorothy M. Davy/Wife Rt. 6, Box 6010 Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Old Pine Cemetery 2010 Purgitsville, WV 21. Signature of Foneral Service Lior nsee 22. Name and Address of Facility Smith Funeral Home Tourn 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial- ransit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Year Day 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ischemic Cardion 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 N 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital ည 1 Yes 2 No Other: 1 Sepatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 Yes Director; A Accident 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) hin 24 hours a the Funeral D mpleted filled Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

within 2

Registrar DHMH 17 Rev 7/2009 (Check

only one) 29b. Signature and title

ABOUL HAVAN CUE

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2006610

12500 Willow Brook Rd Cumberland MO21502

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Depar	tment of Health and Mificate of Death	ental Hygie	ene 0   0	03208
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medic		Norma Lee Davy			30, 2010	0514 M
	Examin			b. City, Town, or Location of Death		4c. County of Death	
			Allegany Health Nursing & Rehab	Cumberland If Under 1 Year   If Under 24 Hrs.	O. Data of Right	Allega	
	Funeral Director			Months Days Hours Min.	8. Date of Birth	(ear) Cour	place (State or Foreign vill, e WV
			Usual Residence of Decedent		12/20/	33 Hays	viii, c wv
	yland how		10a. State 10b. County 10c. City, Town or Loca			]	10d. Inside City Limits
	B Ma	ctor	WV Mineral Piedmon	t			1 <b>√</b> Yes 2 No
	ith th	Dire	101 Second Street	10f. Zip Code 26750	10g	J. Citizen of What Cou	ntry?
	s 23a	rai			acifu Vac as Na	USA 14. Race - Americ	nan Indian
36	d within 72 hours after death with the Maryland jene. Ir then "naturel", or Itams 23a or 28a-f show the Modical Exposit per must be motified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐	as Decedent of Hispanic Origin? (Speces, specify Cuban, Mexican, Puerto Yes 2 No Specify:	Rican, etc.)	Black, White, Specify:	etc.
8	hour		15 Decedent's Education 16a Deceden	nt's Usual Occupation	16	Wn Sb. Kind of Business/In	<u>ite</u>
7.	in 72 n "na	Completed	(Specify only highest grade completed) (Give kii	nd of work done during most of worki ONOT use retired)	ng		,
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b	be filed ital Hygi d other event, II	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name			
ylai		2	William Simmons		a Parke		
Maryland 21215-0036	2 sho			Address (Street and Number or Rura			
e, l	s 1 and 2 should f Health and Men Item 27 Is merke other treumatic	13		Second St., P		oc. Location - City or To	
10	Pages nent of I int: If Its iry or o		1 XBurial 2 Cremation 3 Removal from State	tory or other place) e Cemetery 2/0		Maysville	
Baltimore,							, wv
Ba	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee  22. M. P.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	arkwood Funera	1 Home,	Inc.	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac of	eyser or respiratory afres	WV 26726	Approximate Interval Between
	Physician	5 0	Immediate Cause (Final disease or condition				Onset and Death
	/Medical		resulting in death)  Due to (or as a construence of):	+ +	+		
	Examiner		Squentially list conditions. If any leading to immediate  b. Une to (or as a consequence oi):	Tract injec	lion		
0	led sit	nine	S pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
٢.	be executed sician and burial-transit	Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
760,	te be executed ysician and te burial-transit	calE	d				
89	leath certificate b attending physic I for use as the b	edi	Teerine Teerine				
Вох	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of deliv Month	ery Day Year
	e dea the at	sici		Other (specify)		World	Day Toal
P.0	that the de led by the a detached		Part II. Other significent conditions contributing to death but not resulting in the und	eriving cause given in Part I	23e. Did toba	acco use contribute to t	he cause of death?
ds,	signe d be d	d by	CHF.	onying sauso given in rain.		2 No 3 Pro	<b>A</b> .
Vital Records,	w requires ( been signe should be	Completed			24a. Was an	24b. Were auto	opsy findings available
Re	The lav	duic			autopsy performe	prior to co death?	impletion of cause of
ta		a	25. Was case referred to medical	26. Place of Death	1 Yes 2	No 1 ☐ Yes	20 100
Ξ	S 0 0	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	0.1		ce 6 Other (Speci	fy)
n of			27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		28d. Describe how		
Sio	E # : 0	catic	2 Accident investigation	M 1 Yes 2 No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	Hospital or Attendi 24 hours after death. Funerel Director: A etely filled in by the fu		29a. Certifier 1   Certifying Physicien: To the best of my knowledge, death of the best of my knowledge.	occurred at the time, date and place	and due to the cau	ise(s) and manner as	stated
	To the Hospital or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or inve				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	Day, Year)
			Macen MD	Doo 6615	00	1/30/10	
	. 7.		30. Name and address of person who completed cause of death (Item 23a) (Type, Pi				
	14			Ave., Cumberla	and, MD	21502	
	Sta Registi		FEB 0.5 2010 (Month, Day, Year) 32. Registrar's Signature				
	J		FEB 05 2010 Januar B. April				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Nellie L. Dietsch 14:42  $PM^M$ Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. (Month, Day, Year, une 18.1 78 Kentucky **Director** 26 2001 1931 June Usual Residence of Decedent 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 28a-f P.G. Suitland MD 10f, Zip Code 10e, Street and Number 10g. Citizen of What Country? ò Funeral 20746 items 23a 5331 Carswell Ave United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XXNo Black, White, etc. ь 1 Never Married 2XXMarried þ Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 8th College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Medford ၉ George Dowle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5331 Carswell Ave, Suitland, MD 20746 permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Jack Dietsch (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 14 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 1/19/2010 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2XXNo 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed' **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TNo မ 1- Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certiffing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State

30. Name and address of

Registrar

DHMH 17 Rev 7/2009

ppleted cause of death (Item 23a) (Type, Print)

strar's Signature

15,7010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\gamma$ 03210 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9.25 AM John William Dockery, II 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 099 28 5678 1**y** M 2 □ F 73 Months Days Hours **Director** 1936 New Usual Residence of Decedent Charles with the Maryland 10c. City, Town or Location LaPlata 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 633<u>0 Hidden Valley Drive</u> 20646 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married ¥ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: "natural" 3 Widowed 4 Divorced Specify: Black Year or Dates. 1960-62 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Counseling Psychologist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hoftem 27 is marked of frem 27 is marked of rother traumatic ever John William Dockery Gladys Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lavinia Dockery/wife 6330 Hidden Valley Drive LaPlata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity Mem.Garden 1-25-10 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf, MD20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: ပ္ 1 Inpatient 2X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28a. Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner To the best of my knowledge, death ed at the time, date and place, and due to the cause(s) and manner as stati 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 120/10 30. Name and address of person who completed cause (Item 23a) (Type, Print) BII8 GOOD LUCK ROAD LAN HAM, MID 20 706 HECTOR M.D KNOK 32. Ragistrar's Signature

Registrar

DRKIKY

# Baltimore, Maryland 21215-0036

Vital Records, P.O. Box 68760,	Vital Reco	VIVISION OF V
aw requires that the death certificate	sician: The law red	or Attending Physician: The la

			Please	-			ndelible Ink partment of F		•	Are Legible. giene	•
		for State Registrar			<b>,</b>		ertificate of		,	Reg. No. 2	0 03211
Physicia /Medic	al		ELIA	st) re street and number)	-026	24	4h City Town o	r Location of Deat	2. Date of Dea Month	Day Year	0 1215PM
Funeral Director		5. Social Security N 110–36–4	e ASSI umber 6.5	STED LI	(In yrs. la	sast birthday Yrs.	Sei	If Under 24 Hrs Hours Min.	ARK.  8. Date of Birth	h, Year) 9. B	Armae introduce (State or Foreign Country)  Hawaii
e Maryland ia-f show	ctor	Usual Residence of 10a. State MD	10b. County  Anne Ar	rundel		v, Town or i	ocation a Park				10d. Inside City Limits 1 □ Yes 2 ☑ No
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ours after de ral", or Item Examinen		<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li><li>3 X Widowed</li></ul>	ed 2 Married	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		5. 113	l. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛣 No		to Rican, etc.)		nerican Indian, ite, etc. Vhite
within 72 ho ene. <b>than "natur</b> to "exical	Completed	(Spec	15. Decedent's Edify only highest grandary (0-12)	ude completed) College (1-4or 5	i+)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired HOMEMA	during most of wo d)	rking	16b. Kind of Busines	
ild be filed v fental Hygie rked other i itc event,	To Be Co	17. Father's Name (	First, Middle, Last, Macintyr				Homema	18. Mother's Na	me (First, Middle, ence Hall	Maiden Surname)	me .
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'te Medical Examinar must be notified at once.		19a. Informant's Na John Malo	colm Fole			3	208 Kimbe		e Mount	r, City or Town, State, Airy, MD	21771
it. Pages 1 rtment of H rtant: If Ite njury or otl		4 Donation	☐ Cre <i>m</i> ation 3 ☐ 5 ☐ Other (Specif		CE	ingto	position (Name of ematory or other place on Nationa	l Cem.	o. 18, 2010	20c. Location - City of	
permi Depar Impor any Ir		21. Signature of Fu	meral Service Licer	Der			22. Na <i>m</i> e and Addre <b>Barranco</b> 495 Gov. ]	& Sons, I	P.A. Sev Hwy. Sev	verna Park verna Park	Funeral Home
Physician /Medical Examiner		shock, or hea Immediate Cause ( disease or conditio resulting in death)	rt failure. List only Final n	plications that caused one cause on each ling a	ne. DVAr	vcer		ng, such as cardia		rest,	Approximate Interval Between Onset and Death
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w requires that s been signed b should be dete	ed by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									to the cause of death? Probably 4 ☐ Unknown
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	n: To Be	25. Was case referrexaminer?  1 Yes 2	No n	Hospital: 1 ☐ Inpatie	rv	28b. Time	of 28c, Injur	er; 4 □ Nursing I		ne) lence 6 ☐ Other (Spoots) ow injury occurred	ASSISTED Decity) LILING
r Attendin ter death. irector: Aft by the fun	Certification: To	1	5 ☐ Pending investigation 6 ☐ Could not be determined			Injury me, farm, s		k?  Yes 2 □ No	28f. Location (S City or Tow	Street and Number or i	Rural Route Number,
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical Cer	29a. Certifier (Check only one)	1 Certifying Ph	nysician: To the best	of my know	wledge, dea	ath occurred at the ti	me, date and place	e, and due to the	cause(s) and <i>m</i> anner date and place, and d	as stated. ue to the cause(s)
To the within To the comple	Me	29b. Signature and	title of certifie	I AN	in	7	29c. Licens	ie nu <i>m</i> ber 46360	) :	29d. Date signed (Mon	nth, Day, Year) 18, 2010
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Sta Registra	te ar	31. Date filed (Moni	JAN20	2010 32. Registr	ars Signat	g.	parker		- /		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03212 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Januarv Yolanda Viola Ferrogine 2010 08:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Riva Terrace VI Davidsonville Social Security Numbe If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖔 F 143-10-1602 Months Days Hours Min. 1092271916 New Jersey **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Davidsonville 1 Yes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21035 by Funeral 1098 Galway Road United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black. White, etc. 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Specify: White should be filed within 72 hours and n and Mental Hygiene.
7 is marked other than "natural", 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Perri permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Anthony Pingitore 19a. Informant's Name/Relationship (Type, Print)
Dolores Gibbons/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iselin Lane, Oceanport, New Jersey 07757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State William C. Doyle Cemetery 01/21/2010 Wrightstown, New Jersey 4 Domation 5 Other (Specify) 21. Sign your of Funeral Saving Lic. 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ hronic a Warnows disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Que to for as a consectionne off Exam attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 9 Unknown detached ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 LUnknown peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page ☐ Yes 2☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tyes 2 🗌 No Accident Investigation Suicide
Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 41816 20/0 20

DHMH 17 Rev 7/2009

State

Registrar

Old Solomon, Island Rd.

30. Name and address of person who completed cluse of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN21

2010

139

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year C. FARRIS 2010 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL ANNIAPOLIS ANNE ARUNDEL CENTER ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/28/1925 Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 25 Months 422-22-0157 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm. Medical Event in the medical Event 10a. State 10c. City, Town or Location 10d. Inside City Limits Shady Side Anne Arundel Director MD 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20764 USA 1464 Columbia Beach Rd. Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2√XNo Specify: 3√√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept of Agriculture Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E. Caraway Mittie Ballord ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 657 Shady Side, MD 20764 Leah Moreland Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2010 Arlington National Arlington, VA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License Date Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) ONE DAY /Medical Due to (or as a consequence of): Examiner LOSTRIDIUM DIFFICILE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1X Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001

Parkway

29d. Date signed (Month, Day, Year)

Limothy 31. Date filed (Month, Day,

29b. Signature and title of

Year) Registrar's Signature JAN21

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:05 a M 2010 Figliola Rose Μ. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 41515 Singletree Drive Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday **Funeral** Days 1 M 2 X F Months Hours 03/19/1916 New York Director 93 053-03-5439 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho dical Examiner must be notified at Director 1x Yes 2 □ No New York **Oueens** Ozone Park 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral U S 11417 94-27133 Avenue within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced White Page 1 and 2 should be filed within 72 hours iment of Health and Mental Hygiene.

The Trie marked other than "natur trant. If item 27 is marked other than "natur trant." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Industry 8 Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Molinaro Michael Murno Rosina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41515 Singletree Drive, Leonardtown, MD 20650 Debra Savillo/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of I Important: If ite any injury or ot 1 Durial 2 Cremation 3 K Removal from State 02/03/2010 4 Donation 5 Other (Specify) Farmingdale, NY 21. Si natura Funeral Service Densee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician Gastric Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): ending physician and use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Day Pregnant at time of death 5 Other (specify) the t Unknown P.O. been signed by I should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed <u>Hypertension</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6X Other (Specify) Residence 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer 1 Natural 5 Pending work r death. 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

24 hours within 24 hor To the Fune completed fi 5 RME Registrar

31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29b. Signature and title of certifier

Suresh Patel,

State

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22650 Cedar Lane Court, Leonardtown, MD 20650

29d. Date

signed (Month, Day, Year)

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Page ment ant: It			5 Other (Specify			r. Foa						Ri	ising	Sun	, MD		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fe	neral Service Licens	see 7/	•		22. Name	and Addre	ss of Facili	ity Gee	Funera	1 Hc	nme				
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that the ed by detac			ficant conditions co	ntributing to death b	ut not resu	ulting in the	underlying	g cause giv	en in Part	l.	23e. Did	tobacco	use contr	ibute to t	he cause of death?		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medical Exam	/sician: To the best iner: On the basis of and manner sta	of examina	wiedge, de ition and/or	ath occurr investigat	ed at the till ion, in my d	me, date a pinion, de	and place, eath occur	and due to the red at the tim	ne cause e, date a	e(s) and ma and place, a	anner as : and due t	stated. o the cause(s)		
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2		30. Name and addr	ress of person who co	ompleted cause of c	leath (Item	n 23a) (Type	e, Print)	-	J OLC	10		16	740	7	- 2010		
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Sta		31. Date filed (Mon		32. Registr	ar's Signa	ture	,										
Registra	ar	JAN 2	SAMU /	Lucia D	. 1	-											

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Lest) Date of Death Month 3. Time of Death PON treshman 9:00 PM January 16, 2010

1 - For State Registrar

Physician

	Examin	_	4a, Facility Name (If not institution, give street and number)	T	4b. City, Town, or	Location of D		4c. County of Death			
			Letizens Care-Rehah		Frederi	ck		İ	Frederick		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	-	If Under 1 Year Months Days	If Under 24 Hours N	Hrs. 8. Date of I	Birth Day, Yea	ar)	9. Birthplace (Sta	0
	Director		173-03-1254 1\(\overline{\text{IM}}\) \(\overline{2}\) \(\overline{\text{F}}\) 94 Y	rs.	Months Days	, riodio	Dec.	2,	ľ915	Pennsylv	ania
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	er de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	NO-	14. Race - American Indian, Black, White, etc.		
2-003p	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exaculment to notified at	ρ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII	1	∐Yes 2,527,No	Specify:			Specify	y: White	
2	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If the 21 is marked other traumatic event, the Medical Examinar mast to realling at other traumatic event, the Medical Examinar must be realling at	Completed	(Specify only highest grade completed) (	Give ki	ent's Usual Occup ind of work done of O NOT use retired	during most of	working	16b	Kind of Bu	usiness/Industry	
7	within jene. than "	E O	Elementary/Secondary (0-12) College (1-4or 5+)		nist	•/		Fa	abric	ation	
5	filed Hyg Sther ent, I		17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Midd	le, Maio	en Surnan	ne)	
Ē	d be ental	o Be	LeRoy Freshman			Pos	se Perry				
5	should be ind Mental marked o	၉			nher. Cii	v or Town	State Zin Code)				
Š	19a. Informant's Name/Relationship (Type. Print) 기9b. Mailing Address (Street and Number or Rural Route Number) 기9b. Mailing Address (Street and Number or Rural Route Number) 19b. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route Number) 19c. Mailing Address (Street and Number or Rural Route										
a,	1 and 2 Health tem 27 other tr		20a. Method of Disposition 20b. Place of I	Disposi	ition (Name of		nuary 20			- City or Town, State	e
Ē	Pages nent of int: If i		1⊠Burial 2 □ Cremation 3 □ Removal from State 4□Donation 5 □ Other (Specify)  Res Memor	tha ial	atory or other place ven Gardens	e) Ja	nuary 20 2010		ederi	ick, Mary	land
pallimor	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	1	21. Signature of Service Licensee	Res	Name and Addre	ss of Facility Funeral				Cody P.A	
	20 = # O			1950	Ol Catoc	tin Mou	intain Hy	y]	Frede	rick. MD	21701
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or hear failure. List only one cause on each line.	ot ente	r the mode of dyir	ng, such as car	rdiac or respirator	arrest,		Approxi Interval Onset a	mate Between and Death
F	Physician	ĺ	Immediate Caus (Final disease or condition	2	Cardio	Jas con	luda	alre	12	54	
J.	/Medical Examiner		resulting in death)	f):							-
Cognition list conditions											
-	g t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  b.  Due to (or as a consequence of cause.)	1).							
	and trans	аш	that initiated events resulting in death) Last  Due to (or as a consequence of	6).							
Š.	be ex		resulting in death) Last Due to (or as a consequence of	1):							
00/00	hat the death certificate be executed so by the attending physician and detached for use as the burial-transit	Physician/Medical	d								
р Х	sertifi ding se as	Me	IF FEMALE: 23c. If yes, outcome of pregnancy								
Š O	atten for us	ian	in the past 12 months?		Ectopic pregnanc	у				ate of delivery onth Day	Year
o	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	511	Other (specify) _			-			
Ľ	that the	P	Part II. Other significant conditions contributing to death but not resulting in	the unc	derlying cause give	en in Part I.	23e. Di	d tobacc	o use con	tribute to the cause	of death?
S.	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	b			, , ,		11	Yes	2 No	3 ☐ Probably 4	Unknown
Records	requ	Completed									
ě	e law has	g					24a. W	topsy	i	Were autopsy finding	of cause of
- -	i; Th icate ; pag	ខ្ល	- 17 H				1 □Ye	rformed 2	No	death? 1 ☐ Yes 2 No	
I	Ician certif ector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Oth		Death (Check on				
5	Phys this al dir	P.	1 Inpatient 2 EH/Out		3 🗆 DOA	4 Nursii	ng Home 5 ☐ R				
5	ding h. After funer	ion	a chang	jury	28c. Injur Worl	yat k? Yes 2∐No	28d. Descrit	e now II	ijury occur	rea	
<u> </u>	death death stor: / the	ical	3 Suicide 6 Could not be 28e Place of Injury - At home farm	m etra		Tes Z 🔲 No	28f Location	/Stmo	and Numi	har or Pumi Pauta	Number
2	afor A after Direct of in by	ertification:	4 ☐ Homicide determined building, etc. (Specify)	11, 31100	or, ractory, office		City or	own, Si	(Street and Number or Rural Route Number, wn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, and manner stated.	death dor inve	occurred at the tile	me, date and popinion, death	place, and due to to occurred at the tin	he caus ne, date	e(s) and m and place,	nanner as stated. and due to the cau	se(s)
	Northin Somp	Me	29b. Signature and the of certifier		29c. Licens	e number		29d.	Date signe	ed (Month, Day, Yea	ar)
			Xapril L. Karknown		12	1397	1	1	/19	110	
			30. Name and address of person who completed cause of death (Item 23a) (7	Гуре. Р	rint)	- ( /	/	-	11		
	20+1	VH	Robert L. Kaufmann, M.D. 300 West		,	Frede	rick. MT	21	701		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	h	Brakel	, IIEUE	LICIC ELL		VI.		
	Registra	ar	JAN 20 2010 Ceneral	9. 1	7						

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State of Ma	ai yiai iu	•	rtificate				Reg. No. (	2010	03217
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				_		2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic		Owen B. Frazee			<del></del>				Januar	7 24,	, 2010	7:00 P M
	Examin	er	4a. Facility Name (If not institution, give				1		ocation of Death			County of Death	
and the			Oakland Nursing  5. Social Security Number 6. Se		enter e (In yrs. las	t hirthday)	Ual If Under	kland	If Under 24 Hrs.	8. Date of Birtl		arrett	place (State or Foreign
	Funeral Director			₹M 2□ E	6	Yrs.	Months		Hours Min.	8. Date of Birtl (Month, Day 03-19-	1923	Cou	intry)
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Many Ff sh	tor	MD Garrett		Oal	kland							1 XYes 2 No
	n the	irec	10e. Street and Number		1		10f. Zip	Code			10g. Citiz	en of What Cou	ntry?
	23a c	al [	1141 Memorial Dri	ve			21.	550			Un	ited St	ates
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a Modical Eventinal must be notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Deced f Yes, spec I □ Yes 2			pecify Yes or No- Rican, etc.)		4. Race - Amer Black, White, Specify:	
9-0	2 hou	ted	15. Decedent's Ed	ucation		16a. Deced	dent's Usua	d Occupati	on		16b. Kin	d of Business/li	
218	hin 7. e. Medi	ple	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	5+)	(Give life. E	kind of wor DO NOT us	rk done dui se retired)	ring most of work	ding			
	d wit	Completed	7		.,	Fari	n				Far	ming	
pu	tal Hydra doth	Be	17. Father's Name (First, Middle, Last)					1	8. Mother's Nam	e (First, Middle,	Maiden S	Surname)	
yla	Men Arked arked	ဥ	Carl Frazee						Emma M	argro			
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (7	. ,			•			ral Route Numbe	-		ip Code)
	l and fealth		Linda Thomas, Dau 20a. Method of Disposition	ghter	OOb Die					Dakland,		21550 ation - City or T	aum State
Baltimore,	Pages nent of I ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ce of Dispos netery, cren rett (	-		01/2 orial G	7/2010		akland,	
Balt	permit. Departr Importa any Inji	5 /	21. Signature of Funeral Service Licens	14 2 5			Name an	d Address	of Facility Burdock	Funeral Oaklan	Hom	e, P.A.	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	d the death.	Do not ente						21330	Approximate Interval Between
	Physician /Medical	60 9	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	11/1/4	to	64	et					Onset and Death
	Examiner	-	Sweentially list conditions.	b. Due to (or as	ERA	100 70	a	sati	al 91	4/45			LEEKS
	ecuted and transit	Examiner	Suspentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· Acuta	2 Ne	- S	TRI	Evesta	al Gi				WEEKS
68760,	rificate be executed ig physician and as the burial-transit	Medical Ex	resulting in death) cast	Due to (or as	a conseque	nce of):							WEEKS YEANS
99	ng ph as th	Med	IF FEMALE:								- 1		
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3 [	Ectopic pi Other (sp				2:	3d. Date of delin	very Day Year
σ.	that ned b		Part II. Other significant conditions co	entributing to death be	ut not resulti	ng in the ur	nderlying ca	ause given	in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
rds	quires t in signe	d by								1 🗆 Y	es 2	No 3□ Pro	bably 4 Unknown
Records,	sw requir s been s should	lete								24a. Was a		24b. Were aut	opsy findings available
æ	sician: The law certificate has l rector, page 2 s	Completed		*						autop	med?	death?	ompletion of cause of
Vital	slcian: certifica rector, p	BeC	25. Was case referred to medical		173			2	26. Place of Dea	1 ☐ Yes th (Check only or		1 ☐ Yes	2 🗆 100
f V	nysic nis ce direc	10 E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 EF	R/Outpatien	it 3 □ DO	Othor		ome 5 ☐ Resid	-	Other (Spec	ify)
n of	ding Phy h. After thi funeral o	듩	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	iry 2	8b. Time of Injury	2	8c. Injury a Work?		28d. Describe h			
Sio	endir eath. or: A he fu	atic	2 ☐ Accident investigation				М	1 ☐ Ye	s 2 No				
Division	tal or Att rs after d al Direct ed in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hom c. (Specify)	e, farm, stre	eet, factory,	, office		28f. Location (S City or Tow	treet and n, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral.	Medical		vsician: To the best iner: On the basis o and manner sta	f examinatio								
	Vith com	Σ	29b. Signature and title of certified			,	29c	. License r	-1 0 0-		29d. Date	signed (Month	, Day, Year)
			174	11/2	1	MAS	1	100	76180	1/		1/20	5/10
	3		30. Name and address of person who o									VD 0155	0
			Kenneth Buczyn				th Sti	reet,	Suite .	l, Oakla	nd,	мр 2155	U
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re _	1						

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $20^{\circ}$ ,  $2010^{\circ}$ January William Lee Ford 5:38 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Deale 611 Deale Road Anne Arundel 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington. DC Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday Funeral Months Days Hours 1 🕅 M 2 □ F (Month, Day, Year) 04/11/195 587-66-8770 58 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10a. State nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor injury or other traumatic event, the Medical Examiner must be notified at. Director 1 🗆 Yes 2 🗓 No MD Anne Arundel Dea1e 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number Funeral U.S.A. 611 Dea1e Road 20751 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 104 Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 If Yes, Give 1969-71 Year or Dates. 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 T Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) construction carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Edna Walker Mae William Henry Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 732 Masons Beach Road, Deale, MD 20751 Mary Ford, sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or other 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 01/21/2010 Alexandria, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licenses 8325 Mt. Harmony Lane, Owings, MD 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) <sup>≮</sup>Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to (presidence or, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2  $\square$  No this certificate has been signed by the and director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **V**o 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Manyer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 Natural 5 Pending 2 🗌 No 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) COUKY 060

State Registrar

1RW 5+1

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 7010 -inda /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number If Under 24 Hrs. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Months 1 ☐ M 2 🔀 F 42 578-96-0191 Director 12-23-67 Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglend. Department of Health and Mental Hyglend. Important: I firem 7 is a marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I're Medical Examiner must be notified at 1 StYes 2 No Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 500 Lebaum St SE 20018 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2, No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 24 TrNo SpecifyBlack ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 12 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Warren Reed Brenda Joyce Hill ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anthony Ford/Son 18th P1. SE Washington DC 20020 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft Lincoln Cemetery 11-22-2010 Bladensburg MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Pope Funeral Home 2617 Penn Ave SE Washington 20020 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Years InTerstition PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year In the past 12 months?
1 ☐ Yes 2 🗷 No Day Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifigr ND 01-07-2010 Ca- A 8/369 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ZIOLI 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Yea Tun. 22, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 2. 1938 Washington, D.C Days 1 □ M 2 🗷 F 579-52-1805 71 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Exprenser must be notified at Anne Arundel Severna Park 1 ☐ Yes 2 🙀 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 689 Faircastle Avenue by Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Median once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 17. Father's Name (First, Middle, Last)
Alphonse Rollins 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Thelma Grimes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1578 Eton Way Melissa L. Schaffer/Daughter Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan. 23, 1 X Burial 2 ☐ Cremation 3 X Removal from State Linton Hall Cemetery Bristow, VA 4 □ Donation 5 □ Other (Specify) 2010 22. Name and Address of Facility Barranco & Sons, 21. Signature of Euperal Service Licenses P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 76mos disease or condition resulting in death) ND /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Doe to for as a pansacuance of b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Pruneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1∐Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Ponpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1) Naturai 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date/signed (Month, Day, Year) ame and address of persogryho completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature Year! State JAN20

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	of Marylan					nd Me	ental Hyg	iene		
			State Registrar			Cei	tificate	of L	Death			eg. No. 🤈 🗍	HA	13222
	Physicia	an	Decedent's Name (First, Middle			_					2. Date of Deat Month	Day	o Year	3. Time of Death
	/Medic			Hamilton		Gue					January			1:10 PM
	Examin	er	4a. Facility Name (If not institution	, give street and nu	ımber)			,	Location of			4c. County		
-			Northampton		I = 1 - 1/4		Fr If Under 1		rick If Under 24		Data of Birth		deri	
н	Funeral		5. Social Security Number	6. Sex 1X M 2 ☐ F	7. Age (In yrs.	Yrs.		Days	Hours	Min.	B. Date of Birth (Month, Day,	Year)		lace (State or Foreign itry) rvland
	Director		220–28–9018 Usual Residence of Decedent		77					E	Aug 10,	1932	Ma.	Lytanu
	iand ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Mary F <b>fsh</b>	tor	Maryland Frede	rick		Fre	derick	ζ						1 XYes 2 No
	r 282	Director	10e. Street and Number		1		10f. Zip C	Code			1	0g. Citizen of	What Coun	try?
	h with		200 East 16th	Street				217	01			Unit	ed Sta	ates
	deat	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.	S. 13.\	Vas Decede	ent of His	spanic Origi	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		ce - Americ	
9	after or ite		1 Never Married 2 Marr		2 🔀 No		Yes 2		Specify:		,,	Specia		ite
ĕ	be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	d by	3 X Widowed 4 ☐ Divorced	Year or E	Dates:								1111	
21215-0036	"nati	Completed	15. Decedent (Specify only highes	's Education it grade completed)	)	(Give	ient's Usual <i>kind</i> o <i>f work</i> DO NOT use	done di	uring most o	of working	7	16b. Kind of B		of Trans.
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р Б	Hygir Hygir ther		unk 17. Father's Name (First, Middle,	 Last)		1	NOAU (			's Name (	First, Middle, I			
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<u> </u>	12 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event, 11 the traumatic event.	잍	19a. Informant's Name/Relations			19b. Mailir	ng Address (	Street a	nd Number		Route Numbe			Code)
Z	7572	i s	Melanie Bryan/			1440	Tanev	Ave	Dept	of i	Aging F	rederi	ck, M	D 21702
<u>ъ</u>	s 1 and 2 soft Health a item 27 is		20a. Method of Disposition	-	20b. F	Place of Dispo				Da		20c. Location		
9	age: ent o ht: if y or		1 ☐ Burial 2 🖾 Cremation 4 ☐ Donation 5 ☐ Other (S							1/2	2/2010	Woodb	ine,	Maryland
Baltimore, Maryland	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.	. 11	21. Signature of Funeral Service		12 22.		_				n Servi			
m	Depar Impor any ir	e m	Quanta R	Plamas	MOC									, MD 21029
п			23a, Part 1 Enter the disease, or	complications that	caused the deat	h. Do not ent	er the mode	of dying	g, such as c	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician	e W	shock or heart failure. List Immediate Cause (Final	only one cause on	(M.) (1)	1. DI	35700	nete	UE	00	LMONA	424 7	2/5	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	,,,,,,,			1		1 2	, ,	Irans.
and the	Examiner				each line.  ###################################	TTE	SM	D)ci	NG					HEARS
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	nd nd ransi	Examiner	Cause (Disease or injury that initiated events	с									- 1	
Ö,	e exe ian a urial-1		resulting in death) Last	Due to	(or as a conseq	uence of):								
8760,	cate be executed physician and the burial-transit	dical		d										
ဖ	leath certific attending p	Med	IF FEMALE:	00. 1/									1	
Вох	The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 Peta	al death 3	Ectopic pre						ate of deliv Ionth	ery Day Year
O	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unk	gnant at time of a nown	death 5	Other (spe	ecity)						
P.0.	that the de ned by the a		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying car	use give	en in Part I.		23e. Did to	bacco use cor	ntribute to t	he cause of death?
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<u>=</u>	ding Physician: The law h. After this certificate has b funeral director, page 2 s	S				_					1 □Yes	2 140	1 ☐ Yes	2 🗆 No
Ĕ	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe	- A'		(Check only or			
o	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	1 1	Inpatient 2  of Injury	ER/Outpatier 28b. Time o		A Circ	4 Nur		ne 5 🗌 Resid 8d. Describe h			fy)
Division of Vital Records,	Jing J. After funer	ion	1 ☑ Natural 5 ☐ Pendin	g (Moi	nth, Day, Year)	Injury	м [20	Work	? ′es 2⊡N		ou. Describe ii	ow injury occu	iii eu	
S	death death stor: / the	ical	3 Suicide 6 Could	not be 28e. Plac	e of Injury - At h	ome, farm, str					8f. Location /S	treet and Num	ber or Bur	al Route Number,
<u>≥</u>	or Attencafter death	Certification:	4 ☐ Homicide determ	ined build	ding, etc. (Speci	fy)	out, lactory,	011100			City or Tow			ar rioute realizati
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		29a. Certifier 1 Certifyin	ng Physician: To th	ne best of my kno	owledge, deat	h occurred a	at the tin	ne, date and	d place, a	and due to the	cause(s) and r	manner as	stated.
	24 h 24 h e Fur letely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation,	in my o	pinion, deat	th occurre	d at the time,	date and place	, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie		MD.				number		:	29d. Date sign		
			> /belle		· · ·		1	52	649	9		1-8	20-	10
	2		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,	Print)							
	J		Ronald E. Mill	er, M.D.	4 Culwe	ll Dri	ve Mou	int 2	Airy.	Mary	rland 2	1771		
	Sta		31. Date filed (Month, Day, Year)	32,4	Registrar's Signa	ature	1							-
	Registr	ar	JAN Z Z	LUIU LA	arme.	Kl. 2006	12/6/20							

DHMH 17 Rev 1/2001

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

10-00543 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Thomas Anthony Gott State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month **Medical Examiner** 1811 hrs Thomas Anthony Gott January 19, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death North-Beach 7539 Bayside Road Calvert Chesapeake Beach 5. Social Security Number If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Director Months Hours Min 1 X M 216-76-5937 10-14-1958 Marvland Usual Residence of Decedent 'n 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once. 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Francisco. MD Calvert Chesapeake Beach Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7539 Bayside Road USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify Specify: white ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mansfield Edward Lucia Anne Leone 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Q Lucia A. Gott, 7539 Bayside Road, Chesapeake Beach, MD 20732 mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Emmanuel Church Cem. 01-25-2010 Huntingtown, MD 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transi The law requires that the death certificate be executed Physician/Medical UNPENDED X AMENDED 4b per ME g900 2/22/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g [ Unknown P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, should 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of this certificate has performed death? Yes 2 V No Fo the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred cation 1 V Natural 1 Yes 2 No Director: Pending hours after death 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State within 24 hours at To the Funeral D determined Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E January 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] | [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JANUARY **ALPHEUS** LOUIS 8:07A 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Country) Ohio 295-28-0868 1 X M 2 □ F Hours Min. Nov. 6, 1932 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f st be notified Greencastle Penna. Franklin 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 367 South Washington St. 17225 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or iter edical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 X Married 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Year or Dates. 1953-62 3 Widowed 4 Divorced ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO\_NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Dept. Of The Army Elementary/Seconday (0-12) College (1-4 or 5+) Property Officer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental P ပ္ Louis A. Huff Sr. 1 and 2 should be f Health and Ment item 27 is marked other traumatic e Hilda Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline M. Huff /Wife 367 South Washington St. Greencastle, Pa. 17225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date Indiantown Gap National Cemetery 1 Burial 2 Cremation 3 Removal from State 2/1/2010 Annville, PA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home H. Martin 45 S. Carlisle St. Greencastle, PA. 17225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown Seizure di'sord 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: Certificate: To 1💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After i 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; A

completed filled in by the f Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie MDD 69430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West Sev Frederick, mary 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AMMUNP ARY 201V /WU M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Sunrise Assisted Living Annapolis Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. If Unde 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** Days Feb. 4 1925 218-22-5982 Director 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 🗌 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 707 Sydney Terrace 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Yes 2 No Yes, Give 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferdinand Guerth Mary Elizabeth Dorflein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
707 Sydney Terrace Annapolis, MD 21401 John H. Hammond, Sr./Husband Date 20, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Furieral Service Licen Rarranco 495 Gov. 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) **Examiner** MAGEHEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 No 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate funeral director, pag 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 Tes 2/ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifie Name and address of person who combleted cause of death (Item 23a) (Type, MM 445 State 0 Registrar

Amend #8 per f.director AACO. Health Dept State of Maryland / Department of Health and Mental Hygiene State
Registrar 1/27/2010 sa Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time Physician/ Day 923 A M rances orton Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 12402 Madeley Lane Prince George's Bowie 8. Date of Birth (Month, Day, Yea 3 <del>/ 31 /</del> 1956 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🔯 Months Days Min. 53 **Director** 413-98-1875 Tennessee Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Bowie 1XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12402 Madeley Lane 20715 S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. P. C. M. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F Carroll Reece Horton Juanita Bobbie Jean of Health and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura J. Lanier/Sister 571 Freemans Pond Road, Wakefield, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important; If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Lakemont Memorial 1/23/2010 4 Donation 5 Other (Specify) Davidsonville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the control of the cont been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes Yes To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Tes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 2010 5 w 30. Name and address of person who completed caus of death (Item 23a) (Type, Print) America MD Rhee 31. Date filed (Month, Day, Year) Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1934 THNUCE Andrew Hurley 4c. Counfy of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince George's 8927 Rushland Court Ft. Washington #14 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Year) 1 □ M 2 □ F USA 1/21/46 214**488**014 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □XYes 2 □ No Prince George's Fort Washington MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8927 Rushland Court #14 20744 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Journeyman <u>Meat Cutter</u> Giant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tynes Hurley Pauline Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Hurley/son 7805 Klovstad Dr. Fort Washington, MD20744 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State Trinity Mem. Gardens1-22-10|Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf, MD20601 Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure Immediate Cause (Final Ar Terrosc VSEann disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 - No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Examiner requires that the death certificate be executed Box 68760. o ۵. Division of Vital Records,

attending physician and for use as the burial-trar signed by the a peen has certificate **Director**; After this certific d in by the funeral director, Hospital or Attending 24 hours after death. To the Funeral

**Physician** 

**Examiner** 

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show

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Certification: To

Medical

Baltimore, Maryland 21215-0036

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Director

Funeral

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Completed

Registrar

27. Manner of Deat 1 Natural 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 KOS

32. 31. Date filed (Month, Day, Year)

Registrar's Signatur

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 01 Holler 2010 /Medical Lames eroy 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorical Hea JAKLAWD Garrett GumaHCount If Under 24 Hrs. 5. Social Security Number **Funeral** Year! Months 1 X M 2 □ F Days Hours Min Director 214-36-6315 71 14, 1938 Maryland Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at Director MD Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21520 USA 3074 Bumble Bee Rd. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 □Yes 2√ No If Yes, Give Year or Dates: Specify Specify. 3 ☐ Widowed 4 € Divorced "natural" 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Nursery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lyden Leroy Holler Esther Crosco ပ္ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Louella A. Nazelrod/Companion 3074 Bumble Bee Rd., Accident, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Luth. Cem. Jan. 25, 2010 Red House, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee ecomai P.O. Box 275, Grantsville, MD - 0x 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY /Medical Due to (or as a consequence of): Examiner ND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes funeral director, 25. Was case referred to med Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation neral Director: A 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) se of death (Item 23a) (Type, Print) 69 Wolf Acres Drive Oakland MD 21550

fer Do

2316 PM

Birthplace (State or Foreign Country)

White

21520

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

week

Day

1 ☐Yes 2 ☐ No

1 □Yes 2 X No

Registrar DHMH 17 Rev 1/2001

State

10-00677 Shianna Marie H	How	1- For State	or Print in Bla of Maryland /	Departr		Health a			J	2010	0323
Physici	an/	Registrar  1. Decedent's Name (First, Middle,Las	t)	Ocitin		Dodin		2. Date of D			3. Time of Death
Medical Exami		Shianna	a Marie	Howe	S			Month January	Day 23, 201	Year 0	1228 hrs
,		4a. Facility Name (if not institution, giv	e street and number)		41		or Location of D	eath		County of Deat	1
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yany		10a. State 10b. County		10c. City, Tow	vn or Locatio	n					10d. Inside City Limits
show age.	<u>_</u>	MD Calver	t			Princ	e Frede	rick			1 Yes 2 X No
Aaryla 28a-f	Director	10e. Street and Number			T	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
the National States		91 Armory Road				20	678		US	A	
h with	Funeral	11. Marital Status  1 X Never Married 2 Married	12. Was Decedent E Armed Forces?	er in U.S.				( Specify Yes or uerto Rican, etc.)	No- 1	14. Race - Amer White, etc.	can Indian, Black,
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5-0036 iled within 7/ Hygiene. I other than		17. Father's Name (First, Middle, Last)		<u>-</u>		<del></del>	18.Mother's N	lame (First, Middl		•	
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D 2 shoul and M 7 is m	٩	19a. Informant's Name/Relationship (T		38	-			or Rural Route N			, Zip Code)
and 2 lealth tem 2 traum	Carina R. Howes, mother 920 Woods Road, St. Leonard, N										Town, State
Ore loges 1 tt of H tt If i	1 Burial 2 X Cremation 3 Removal from State crematory or other place)										
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Ba Depart Imp	ļ	William R	Cro	-				y Lane,			20736
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Box 68760, e death certificate be the attending physic ed for use as the but		23b. Was decedent pregnant in the past 12 months?	1 Live birth			Ideath 3	Ectopic pre	egnancy			ay Year
OX (	· 🐷 [	1 Yes 2 No 9 ✓ Unknown	4 Pregnant at ti	me of death	5 Othe	er (Specify)					
D. B the d	Phy	Part II. Other significant conditions		but not resulti	ing in the un	derlying cause	given in Part I.	23e. Dio	tobacco us	se contribute to	the cause of death?
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Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed and reflected: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transition and the control of the control	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year)										
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D sspital hours neral y filled	S	4 Homicide determined	(opening)	<del></del> -							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		(Check only one) 2 Medical Examiner	an: To the best of my licensisting of the basis of exami								
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.				nse number	,		ate signed (Mor	
	-	May = 1	10				.M.E.			ary 24, 2010	
		30. Name and address of person who of	completed cause of dea	ath (Item 23a)	)						
		Margarita Korell MD. As		,		n Street. I	Baltimore, M	ID 21201			

State 31. Date filed (Month, Day, Year)
Registrar JAN 2.8 2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 18, 2010 Physician **1540** м Herbert Ernest Hutchison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Oct | 31, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F 84 Maryland Vrs 218-20-0644 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatith and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet rust be notified at 1 ☐ Yes 2X No Director MD Prince George's Upper Marlboro 10g. Citizen of What Country? 10e Street and Number USA Funeral 1421 School Lane 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 DYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify: β 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Construction Superintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Hutchison Genevieve ပ္ Rov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dunkirk, MD 3101 Ashwood Dr. Ron Hutchison (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 20 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2010 Clinton, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. 20736 Owings, MD Goff 8125 Southern Maryland Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Acute Physician Cerebrovasailas Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Carchio vencerlas direase Atheroscienotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş tibrillo Hon 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No mellitu 24a. Was an certificate has 1 □ Yes 2 No Division of Vital After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death.

The Funeral Director: After t pletely filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50653 GYAN .C. Surana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 85 Deale Churchton 32. Registrar Signature 31. Date filed (Month. Day. State 2010 Registrar

		Pleas	e Type or							_		_	ole.	
		For State	State of	f Mar	yland		•		Health and	Mental H	ygien	е		00000
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Hosp 24 hou Fune eted fil	Medical		miner: On the basis	of exam	ination	and/or inv	estigation, ir	n my opinic	n, death occurred	at the time, date	and plac	e, and due to	the cau	ise(s) and manner stated.
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1° a	ŀ	30. Name and address of person who	completed cause		,	, , , , ,	, Print)					-/		
		Peter S. Birk, M	.D. 1082	9 Ge			ve., [	r-2,	Silver S	pring,	Mary	land	209	002
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DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20. 2010 3:35 p. January Knight Jones Irvin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Charlotte Hall Veterans Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/24/1921 Birthplace (State or Foreign Country) XXM 2 F Virginia 88 228-14-3807 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐Yes 2 ☐ No Mechanicsville St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 28410 St. Mary's Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1XXYes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2000 Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Farm Insurance Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loue 11a Knight Frank Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28410 St. Mary's Avenue, Mechanicsville, MD 20659 Brandon Jones/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/27/2010 Montross, Virginia Andrew Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End stage disease or condition resulting in death) Due to (or as a consequence of): Parkinsons dvance Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 48phagia Due to (or as a consequence of) Lrosepsis 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an perform rmea? 2 A No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the burial Division of Vital Records, P.O. Box 68760, certificate has been si rector, page 2 should I this after death Director;

Physician

/Medical

Examiner

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events.

/Medical

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

FRANCISLA

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after

To the Funeral Directory

completely filled in by State

MA

29d. Date signed (Month, Day, Year)

ee of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

29449 CHARLOTTE BRUNKY HAU RD CHARLOTTE HALL 20622

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

31. Date filed (Month, Day, Year)

JAN 2 5 2010

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03235 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Elwood Kraft Ronald January 18, 2010 1:27A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel Anne Arundel Medical Center
5. Social Security Number 6. Sex 7. Age <u>Annapolis</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay Year) 6/20/1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 X M 2 □ F Months Days Hours Min Washington, DC 577-48-0073 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21037 3459 South River Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Elwood Kraft Esther Juanita Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly J. Passero/Daughter 3459 South River Terrace, Edgewater, MD. 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 □ Ren/oval from State Lakemont Mem'l Gardens 1/22/2010 Davidsonville, Maryland

22. Name and Address of Facility George P. Kalas Funeral Home 4 ☐ Donation 5 Other (Specify) of Fungral Service L 21. Signatu Kler 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Methicillin Kesultant Starsh aureur disease or condition resulting in death) Due to (or as a consequence of): Prostatic Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ATION with rapid ventricular respons ATRIAL FIBRILL Due to (or as a consequence of) resulting in death) Last Hypertension 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

law requires that the death certificate be executed Box 68760 P.O.

burial-trans and physician attending physic for use as the b ed by the a detached for signed to icate has been sig page 2 should b certificate funeral director, After this the

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. We float Exp. its country to once.

Physician

Examiner

/Medicat

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

2

Completed

Be

Examiner

Division of Vital Records, **Hospital or Attending** in 24 hours after death letely filled in by

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Registr	a

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2\* ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation Injury 1 M Natural 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

January

DHMH 17 Rev 1/2001

PKWY Ste 100 ANNAPOLIS

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ANDREW GORDON

JAN20

31. Date filed (Month, Day, Year)

2003 Medical

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month uchael. Keenan 1134 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b City, Town, or Location of Death Examiner Baltimere Washington Med Anne Arundel Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) Funeral Months Hours Min 057-48-5160 5 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Severn Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21144 7794 Gabriel Garth 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify "natural", Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other thany injury or other traumatic event, the once. 4 Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Keenan Audrey Scrivener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Keenan Brother 1006 Morgan Station Dr. Severn, MD 21144 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Atlantic 1/20/2010 Glen Burnie, MD Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Lice Date Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin and -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available 24a, Was an autopsy this certificate has al director, page 2 prior to completion of cause of death? page performe 1 Yes 2 No Yes 2 XN 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Yes ျှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Matural 5 Pendina work? 2 | No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) D0069434 16 lizabeth L. MCIIman 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Elizabeth McIlmoyle

DHMH 17 Rev 7/2009

Registrar's Signature

Baltimore Washington Medical Center Glen Burnei, MD 21061

			ricase	State of Maryland				-	•	<b>c.</b>
			for State Registrar	otato of maryland		rtificate of			Reg. No. 2 1	0 03237
	· · ·		1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month		3. Time of Death
	Physici: /Medic		Clark Austin Kol					January	7 26, 201	0 10:20 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv				r Location of Death	'n	4c. County of I	
-	Funeral		31300 Garrett Hig 5. Social Security Number 6. S		ast birthdav)	Accident If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Garret	Birthplace (State or Foreign
	Funeral Director			TVM OFF	37 Yrs.	Months Days	Hours Min.	July 22	v, Year)	Country) Maryland
	pu v		Usual Residence of Decedent  10a. State 10b. County	10c City	y, Town or Lo	ocation				10d. Inside City Limits
	Aaryla f sho	Ď				oution				1 ☐ Yes 2 🔀 No
	r 28a-	Director	MD Garrett  10e. Street and Number	. ACC	ident	10f. Zip Code			10g. Citizen of Wha	it Country?
	death with the Maryland rms 23a or 28a-f show		31300 Garrett Hig	jhway		21520	)		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black, V	American Indian, Vhite, etc.
30	hours after tural", or ite	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2 No If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	Specify:		Specify:	White
9500-61212	be filed within 72 hours after death with the Marylan tall Hygiene.  tall Hygiene.  d other than "natural", or items 23a or 28a-f show event, in mortical Evan, included to make the condition of		15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	
בן: ב	e filed within 72 h al Hygiene. I other than "natu	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of wor d)	rking		
-	led wi tygier her th		12		Farm	er	10 Mathada Nam	no /Eirot Middlo	Dairy Maiden Surname)	
	d be fi	Be C	17. Father's Name (First, Middle, Last, Clarence Kolb	/			Cora Ge		walueri Surname)	
7	2 should be to and Mental is marked or raumatic eve	2	19a. Informant's Name/Relationship (	(Type. Print)	19b. Mailir	ng Address (Street			er, City or Town, Sta	ate, Zip Code)
≥	es 1 and 2 should to of Health and Meni fitem 27 is marked ir other traumatice		Lena Fratz/Daugh	nter	31900	Garrett	Hwy., Ac	cident,	MD 2152	0
ore	Jes 1 a		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	20b. P	lace of Dispo emetery, crer	osition (Name of matory or other plac	ce)	Date	20c. Location - Cit	y or Town, State
Baitimore,	rtmen rtmen rtant: njury		4 Donation 5 Other (Specif	fy) St.					O Accider	
ng Pa	permit. Pages: Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lice	Jamosan		2. Name and Addre			neral Hom , MD 215	
			23a. Part 1. Enter the disease, or com shock, or teart failure. List only	plications that caused the death one cause on each line.	n. Do not ent	ter the mode of dyin	ng, such as cerdiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
F	hysician /Medical		Immediate Ceuse (Final disease or condition resulting in death)		mor	19				2045
e e	Examiner			Due to (ør es a consequ	uence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or es a consequ	ience of):					
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
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	g physics the f		120	▲ d						
ž į	death certifica e attending ph id for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregnanc	ev.		23d. Date o	
	y the at	Physician/Med	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant et time of de 9 ☐ Unknown		Other (specify)			Month	Day Year
Σ.	Ine law requires mat the ate has been signed by the page 2 should be detached		Part II. Other significant conditions	1	-	nderlying cause giv	ren in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
Hecords	equire sen siç ould b	Completed by	2 rd stage	Mon porti	1			1 🗆 Y	es 2 No 3	☐ Probably 4 ☐ Unknown
ec :	has be	nple						24a. Was a autop	an 24b. Wei	re autopsy findings available ir to completion of cause of
<u> </u>	icate								med? dea 2 ☑No 1 ☐	th?  Yes 2 □ No
VITAI	siciar	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ED/0.4#-	ot all DOA Oth	or:	ath (Check only or		
5	g rny er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	ry at	1	lence 6 Other of the object of	(Specify)
101	ath. or: Aft he fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	M 1 □	k?  Yes 2 □ No			
DIVISION	al or Atta	Certification:	3 Suicide 6 Could not b 4 Homicide determined		me, farm, str /)	eet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	to the bospital of Attending Frigstoant. The law requires that bearn certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Medical (		hysiclan: To the best of my know miner: On the basis of examinat and manner stated.						
	vithir To th comp	Me	29b. Signature and title of certifier	10	_	29c. Licens	-: -/	/	29d. Date signed (A	Month, Day, Year)
			1/4//	1/ Ch		110	0618	01	((	27/10
		6	30. Name and address of person who				A MD J	1550		
	Sta	te	Kenneth Buczyński 31. Date filed (Month, Day, Year)	32 Registrar's Signat		, Jaktan	u, PID Z.	1330		
	Registr		JAN 2 8 20	10 Burner 1	7. A					

Registrar

State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Physician 8:46 a January 11, 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Sinai Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 □ M 2 🗷 F Director 89 October 3, 1920 MD 215-26-3288 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Baltimore Gwvnn Oak 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a USA 3902 Chatham Road 21207 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify. þ 3 Widowed 4 Divorced Black "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Performance Analyst 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Brown ٩ Preston Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; if Item 27 is any injury or other tra once. 12095 Olivet Road, Lusby, MD 20657 Rodell Mackall - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Young's Church Cemetery | January 20, 2010 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee/ Glades 1451 Dares Beach Rd., Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final MONTUS **Physician** DEMEN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown this certificate has been sral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 🗆 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 / Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No spital or Attendil nours after death. neral Director: A / filled in by the fu death. 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

(RW)

State Registrar 31. Date filed (Month, Day,

GBEL MD

32 Registrar's Signature

Year!

of death (Item 23a) (Type, Print)

401

PRIVE SUITE 101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J<sup>Month</sup>ary Physician/ 17, 2010 12:05 P M Kehoe, Jr. Henry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Burnett-Calvert Hospice House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F Hours 06-03-1918 Maryland Director 219-03-6165 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 👿 No MD Chesapeake Beach Calvert 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 4930 Chavez Lane 20732 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, 11. Marital Status Armed Forces?
1 

Yes 2 □ No If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced white Year or Dates. 1941-45 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Coach and Athletic Director University of Maryland Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James Henry Kehoe Ethel Mae Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara E. Kehoe, wife 4930 Chavez Lane, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

Burial 2 □ Cremation 3 □ Removal from State
Uponation 5 □ Other (Specify) cemetery, crematory or other place) Emmanuel Church Cem. 01-23-2010 Huntingtown, MD 21. Signature of Funeral Service License any in 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTIPLE CEREBRO VASCULAR P4RS Physician/ disease or condition Medical resulting in death) Examiner THE SELERUTIC CARDIO VASCULAR if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 autopsy page death? After this certificate 1 🗌 Yes 2 🗌 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🖳 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 1 Tes 4 Nursing Home 5 Residence 6 N Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: House Natural work 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEIGER

32. Registra

J8H

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 8 per fh. 9913.03/02/2011dhb

Amended#4a 1- For Amend Items 1,4a per dr., 9000,02705/2016alth and Mental Hygiene

Amended#4a 1- State Registrar 1/25/10, M.S., Kent Co. Certificate of Death

Reg. No. 2010 1. Decedent's Name (First, Middle, Last) Edna Marcella Lewis 2. Date of Death 3. Time of Death Day Year **Physician** 2.45 AM 20 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chestertown Queen Anne If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 88 Days 1□M 2**X**F Months Yrs. 45 219-07-Director 07/04/1921 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f show be notified at 0 1 ☐ Yes 2 No Director -own 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 ondtown by Funeral Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) actory OrKer Campbell 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be harl ines uausta ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 'incl town KÆ 2/620 ht: +2012 hestertown Wendolyn QUR 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any Injury or o cemetery, crematory or other place 1 Burial 2 □ Cremation 3 □ Removal from State Pleasant Cometery: 24 120/0 Donatown, MI) 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 21678 Smith F Worten, MD ammie Koute 298 ennie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 I I Inknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2☐No 3☐ Probably 4☐Unknown 1 TYes Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hipeoton's 24a. Was an page 2 autopsy performed? Yes 2 No Insulin Depende certificate 1∐ Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Dale signed (Month, Day, Year) mi. 600 2010 100/7036 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jusen K. 1035 mD 516 m -31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar bressan

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, for State Registrar 03242 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOHN WILLIAM 27, 2010 8:45 P. M **JANUARY** LEE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 09/17/1910 5. Social Security Number 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** MARYLAND 1 2 M 2 □ F 217-10-7041 Director 99 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director ALLEGANY CUMBERLAND MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with **#1 BALTIMORE STREET** 21502 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE CLERK of INQUIRIES & CLAIMS 12 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental ANNA VIOLA BISEL ည WILLIAM BENEDICT LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1007 ARMSTRONG ROAD, CARLISLE, PA ELIZABETH KERCH / DAUGHTER If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 5 ppurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. SUNSET MEMORIAL PARK 01/30/2010 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) HAFER FÜNERAL SERVICE, P.A. 1302 NATIONAL HIGHWAY, LAVALE, 21. Signature of Funeral MD 21502 MOCKEUCE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONCESTIVE HEART /Medical Due to (or as a consequence of) Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Examin burial-trar Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performe 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 2 🗌 No n 24 hours after death.

The Funeral Director: Appletely filled in by the fu 1 TYes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hum 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sh Rd. Cumberland, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 15 45 PM Lynch rances anuar 28 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kent River Hospital Center hester town | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 11, 1924 If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Country) Delaware 1 □ M 2 □ F 221-12-2046 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Item Medical Evandors and bonotified at 1 Yes 2 XNo DE Milford Funeral Director Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 19963 81 Wayne D Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lydia Sheppard Thomas Mills ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health Harriet Schurman -Daughter 17N. Horseshoe Dr., Milford, DE 19963 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Milford Comm. Cem. 2-1-10 Milford, DE 22. Name and Address of Facility Berry-Short Funeral Home 21. Signature of Funeral Service Licensee 119 NW Front St., Milford, DE 19963 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CANDIO RESPINATIONY ARRE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner (AND/06CALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner PORTSUMED ISCHEMIC Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) ours after death. erail certificate has been signed by the attending physician eral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 BROWN ST CHOSTENSONA, MO 21620 R. JOHNSON MD

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 5 201

DHMH 17 Rev 1/2001

# Physi Me Exar Fune Direct permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. Baltimore, Maryland 21215-0036 Physicia Medic Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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	. ,	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	David Maria	3. Time of Death
cia: dic		James Bruce Lawrence				January	18, 2010	1:10 A.™
nin	er	4a. Facility Name (if not institution, give street and number)  12008 Rockledge Drive		4b. City, Town, or Bowie	Location of Death		4c. County of De	George's
al		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year		8. Date of Birth	9. B	irthplace (State or Foreign
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	Completed by Funeral Director	10a. State 10b. County  Maryland Prince George's	10c. City, Town or Loc	cation				10d. Inside City Limits 1    Yes 2 □ No
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	era	12008 Rockledge Drive		2071.	5		U.S.A.	
	ᇤ	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V	Vas Decedent of His	spanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No-	14. Race - Am	
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	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, Mai	den Surname)	
	٥	Zeno Francis Lawrence			Elizabeth	1	Fritts	
		19a. Informant's Name/Relationship (Type, Print)		-	nd Number or Rural F			
		Terry B. Reynolds/Partner	20b. Place of Dispo		ge Drive,	-		20715
		1 🗆 Burial 2 🛛 Cremation 3 🗀 Removal from State	cemetery, crem	natory or other place	•		c. Location - City o	
ø		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	Fleck	Cremator	y $1/20/2$ s of Facility $Robe$		aurel, Ma	
ouce.		> And friend			polis Road			
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente	r the mode of dying	, such as cardiac or r	respiratory arrest,		Approximate Interval Between
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	Medical Certificate:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of moly one)  1 Certifying Physician: To the best of moly one only on	amination and/or invest	igation, in my opinior leath occurred at the	n, death occurred at the time, date and place,	e time, date and p and due to the car	place, and due to the use(s) and manner a	cause(s) and manner stated. s stated.
		29b. Signature and title of certifier	500	29c. License	_	) 29d	Date signed (Mont	th, Day, Year)
e.		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, P		Drive	Leiver	4 /4	and and
tat	е	31. Date filed (Nanth, Day, Year)	's Signature	pilar	5.1.		11	1
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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OWERY 2010 074 Medical 4a. Facility Name (if not institution, give street and number) 48. City, Town, or Location of Death 4c. County of Death
Prince George's **Examiner** Upper Marlboro 15609 Croom Airport Road Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign WfTTamsburg, PA 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 M 2 D F Days Hours Min FeBth, 23, Year 1919 90 **Director** 233 12 6475 Usual Residence of Decedent 10a State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Start If item 27 is marked other than "natural", or items 23a or 28a-f shor iury or other traumatic event, the Medical Examiner must be notified at ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 Tho MD Upper Marlboro Prince George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 15609 Croom Airport Road United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify: 3XXWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Construction Business Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Myrtle McCormick William Darlington Lowry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15609 Croom Airport road, Upper Marlboro, MD 20772 William Lowry (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 23. 20c. Location - City or Town, State Department of Important: If it any injury or o 1 A Burial 2 Cremation 3 Removal from State Patrick Memorial Gardens 4 Donation 5 Other (Specify) Stuart, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funer | Service Lice Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Pnysiciani RUSTATE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impuly that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be et 24 hours after death.
24 hours after death.
25 Hoursal Director: After this certificate has been signed by the attending physicial red filled in by the funeral director, page 2 should be detached for use as the burn set of filled in by the funeral director, page 2 should be detached for use as the burn. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Live Birth 2 L. retail 400.

Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a, Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, seat recovered at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number ho completed cause of death (Item 23a) (Type, Print) Name and address of person 1441 FENSE ENTEM HIGHWAN MICHAEL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		-	For State Registrar		State	OI IVI	aryiano		rtificate of	Health and Death	ivientai ny	Reg. No	2010	03246
	Physicia	n/	1. Decedent's Nam								2. Date of D Month	eath Da	21 <b>,</b> 201	3. Time of Death
	Medic	al	Migu 4a. Facility Name (ii		Gallardo	_	Lop	ez	Ab City Town	or Location of Death	Janua		21, 201 201 c. County of Dea	
	Examin	er	291 Sout		-					unkirk			Anne Ar	
	Funeral Director	10	5. Social Security N 577-74-9	lumber	6. Sex 1 <b>X</b> M 2 □ F	7. Age	e (In yrs. Ia:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9, B	irthplace (State or Foreign puntry) Llippines
	how at	'n	Usual Residence of 10a. State	Decedent 10b. County		Т	10c. City	, Town or Lo	ocation	-				10d. Inside City Limits
	Aarylar 8a-f s tified	Funeral Director	MD	Anne	Arundel				]	Dunkirk				1 ☐ Yes 2 🌠 No
	h the h ka or 2 be no	al Di	10e. Street and Nu	mber					10f. Zip Code			10g. C	itizen of What C	ountry?
	ath wit	uner	291 Sout	hland	Court 12. Was Dec	redent F	ver in ILS	13		20754	pecify Yes or No	- 1	USA 14. Race - Am	orican Indian
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Man		ried Armed F	orces?			If Yes, specify Cub  1 ☐ Yes 2 🔀 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	o Rican, etc.)		Black, Whi	
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ylar	ld be f Menta arked atic e	욘	Evaristo	Vi11	asor Lop	oez		•		Marina	Casti	.11o	Gallar	do
Maryland	shou h and 7 is m traum		19a. Informant's N							and Number or Ru				
	Healt Healt Hem 2		Rosaling 20a. Method of Dis		opez, w	<u>ife</u>	20b. Pl	ace of Disp	osition (Name of	d Court,	Dunkirk Date		0 20754 _ocation - City o	
E O	Page Tent of		1 X Burial 2 4 Donation	☐ Cremation 5 ☐ Other (5	3 Removal from Specify)	m State			matory or other pla ans Ceme	tery 01-2	8-2010	Ch	eltenha	m. MD
Baltimore,	permit. Departm Imports any inju		21. Signature of Fu	neral Service L	icensee		_		2. Name and Addre				al Home	, P.A.
ш	90 <b>5</b> 89	Н	220 Part 1 Fator	lan	K. ORe	) aquad	the death			Harmony L			s, MD 2	0736
	Physician/ Medical			irt failure. List o (Final on	a.	each line	rent	52 A		remove		irrest,		Approximate Interval Between Onset and Death
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09	ate be ohysici the bu	dica			d								-	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 horus after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2 9 Unknowr	months? ☐ No		e Birth egnant at		death 3	☐ Ectopic pregnar ☐ Other (specify) _	псу			23 <b>d.</b> Date of d Month	elivery Day Year
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l Re	rsician: The law r s certificate has b lirector, page 2 s		25. Was case refer	red to medical	1				00.5	None of Dooble (Cho	1 🗆 Yes	2 <b>2</b> N		es 2 🗆 No
Vita	ysicial s certi directo	To Be	examiner?		Hospital:	] Inpatie	ent 2 🗆 I	ER/Outpatie		Place of Death (Chener: 4  Nursing F		sidence	6 ☐ Other (Spe	ecify)
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ion	l or Attending I after death. Director: After I in by the funer	tifica	2 ☐ Accident 3 ☐ Suicide	Investi 6   Could	gation	a af lair	At her		M 1 🗆	Yes 2 No	001	/O11		Don't Month
Division	To the Hospital or Attending Physician: The Is within E4 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical Certificate:	4  Homicide	3	build build	ding, etc	. (Specify)		reet, factory, office		City or To	wn, State	e)	ural Route Number,
	To the Hospital within 24 hours To the Funeral completed filled	Medic	(Check only one)	Medical I	xaminer: On the b Nurse Practione	asis of ex	kamination	and/or inve	stigation, in my opin death occurred at t	he time, date and pla	at the time, date	and place the cause	e, and due to the (s) and manner a	e cause(s) and manner stated s stated.
	with		29b. Signature and		P. Ster	ne	m,	۵.	29c. Licens	D17245	5		ate signed (Mon	
70,	Itn. G		30. Name and add	ress of person	who completed ca	use of de	eath (Item	23a) (Type,		D1- D	-1 0 :		MD 00	700
	V \o√ Sta	te	Gerald 31. Date filed (Mon	th. Dav. Year)	32	Registra	ris Signati	ure	-	Beach Ro	ad, UW1	ngs,	20 עוז	732
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ORIGINAL

Amend#12 per F AA Co. Health	un Dep	t lo	<b>pe or Prin</b> State of Ma									gible.	
Physicia	ın/	State Registrar  1. Decedent's Name (First, Middle, Last)		,		tificate				2. Date of Dea	Reg. No. 2	)   ()	0 3 2 L 7 3. Time of Death
Medic Examin	cal	Richard E. Mould  4a. Facility Name (if not institution, give stree  Anne Arundel Med	t and number)	enter	-			Location o	of Death	<u>Janua</u>	4c. Count		
Funeral Director		5. Social Security Number 6. Sex 1 2 2 2 - 26 - 9112 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		(In yrs. last b	irthday) Yrs.	If Under Months		If Under : Hours	24 Hrs.	8. Date of Birt ept <sup>(Month, De)</sup>	h / Year 923		nplace (State or Foreign oty)1and
Aaryland 8a-f show tified at	rector	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Aru		10c. City, To		nvil	le						10d. Inside City Limits 1 ☐ Yes 2 🕅 No
n with the N rs 23a or 2 nust be no	Funeral Director	10e. Street and Number 3437 Riva Rd.					103				10g. Citizen of US		untry?
036 s after death ral", or item Examiner n	ρ	1 Never Married 2 Married	Was Decedent Ev Armed Forces? 1 → Yes 2 → Yes If Yes, Give Year or Dates. 10	<del>10-</del>	If	Vas Decede Yes, speci	ify Cubai	n, Mexican	, Puerto Ri	ify Yes or No- ican, etc.)	Bla	ce - Amer ick, White v: B1 a	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Educat (Specify only highest grade co	ion	16	(Give k	ent's Usua kind of work NOT use V <b>il</b>	k done d retired)	luring most	_	9	16b. Kind of E		
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, Mary nd 2 should eath and M n 27 is mar ier traumat		19a. Informant's Name/Relationship (Type, Roger Moulden (So		1:	9b. Mailin	g Address 00 Re	(Street a	ew C	er or Rural P	Route Number	r, City or Town, rt Was	State, Zip	Code) 20744 gton, Md.
altimore, rmit. Page 1 and partment of Hea portant If item y injury or other		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		ro C	rema	ther place tor	У	1-15	- 1		more	e, Md.
Bal permit Depar Impor any in		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complicate	MOO		8	21 W	lest	St.	Ann	apoli	uary, s, Md.		
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Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal de		] Ectopic p ] Other (sp		у				ate of deli	very Day Year
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by a land the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	Certificate:	Natural 5 Pending Control Pend	(Month, Day, 28e. Place of Injur building, etc.	ry - At home,	injury farm, stre	M eet, factory		? Yes 2 🗆		8f. Location (S City or Tow		ber or Run	al Route Number,
Di e Hospital of 124 hours a e Funeral D	Medical 0	29a. Certifier 1.2 Certifying Physicial (Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of ex-	amination and	d/or invest	igation, in r	ny opinio	n, death oc	curred at the	he time, date a	nd place, and di	ue to the c	ause(s) and manner stated.
To the within To the comp		29b. Signature and title of certifier	ter	~	Λ,	29c.	D 2	number 7	43		29d. Date signe	/	, Day, Year)
2+1	)	116 Defense Hw 31. Date filed (Month, Day, Year)	leted cause of de	eath (Item 23a	a) (Type, P	Print)	214	01	H	dwar	dD.	Gol	Steinus
Sta Registr		JAN 2 0 2010	Genera	A.,	par	4							

5. Social Security Number **Funeral** 527-02-1704 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 28a-f show Department of Health and Mental Hygiene. Important: If item 2.73a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Experiment and be notified at once. Director MD 10e, Street and Number Funeral 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Ciro Minopoli မှ 4 ☐ Donation 5 ☐ Other (Specify) aus Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical

State Registrar

1. Decedent's Name (First, Middle, Last)

January Physician 21, 2016 6:40P Franco Pasquale Minopoli /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4638 Diamond Ridge Lane White Plains
er 1 Year | If Under 24 Hrs Charles 4 1 2 9. Birthplace (State or Foreign Country) 1taly If Unde 8. Date of Birth October 4,1933 7. Age (In yrs. last birthday) Months Days 1 M 2 □ F 76 Yrs. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Charles White Plains 10f. Zip Code 10g. Citizen of What Country? 20695 4638 Diamond Ridge Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Plant Operator Sanitary Commission 18. Mother's Name (First, Middle, Maiden Surname) Emilia De Rosa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margherita Minopoli/Wife 4638 Diamond Ridge Lane, White Plains, MD 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Trinity Memorial Gar. 1/26/2010 | Waldorf, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility M00945 AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ehul 20646 Approximate Retw Interval Between Onset and Death Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Machur, M. D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene?

2. Date of Death

03248

3. Time of Death

Registrar DHMH 17 Rev 1/2001

State

illed in by the f

within 24 hours a

Examiner

physician and the burial-tran

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:50 AM Ronald Jan 15. McAllister, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours 044 42 9198 59 Director April 6. 1950Bridgeport, Conn Usual Residence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Institute 23a or 28a-f show Important: If fine a 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its "Modisal Exprisine must be notified at 1 X Yes 2 □ No Director DC n/a Washington 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2907 Stanton Road S.E. Apt 203 20020 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XIXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ∐ Yes 🏋 🟋 No Specify: Specify: Black ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Adams Jessie McAllister, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 19a. Informant's Name/Relationship (Type. Print) Cecelia McAllister, (Wife) 2907 Stanton Road S.E. Apt 203, Washington, DC 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) n 25, 2010 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Maryland Maryland Veteran Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d mo1533 21. Signature of Funeral Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that conshock, or heart failure. List only one cause on experience of the constant of the con Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events satisfied beats). Due to (or as a consequence of) Examiner burial-transit and resulting in death) Last Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - NC To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Yes Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Could not be determined 3 Suicide L ce of Injury - At home, farm, street, factory, office billding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and titl

State Registrar

Arastoo Yazdani, M.D. 9135 Piscataway Road, Suite 235, Clinton, MD ate filed (Month) Pay, (Year) 1034 a 32/Registrar's Signature

30. Name and address of person who of

Registrar's Signature

leted cause of eath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:55 A M 25, Dorothy Rosalie Morgan 2010 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🔀 F 215-62-8706 79 March 20,1930 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a, State show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat mast be notified at 1 ☐ Yes 2X No Director Maryland St. Mary's Mechanicsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 39860 New Market Turner Road 20659 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ∐Yes 2 🙀 No Specify. Specify: White þ 3 ⅓ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 5 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Frances Knott Camillus Theodore Morgan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mechanicsville, MD 20659 39899 New Market Turner Rd. Jimmie Lee Morgan / Son item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 29. Department of Important: If it any Injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Charles Memorial Gardens 2010 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 200 Leonardtown, MD 20650 Lennett. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SCU D Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 2 X No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate ha 2 📮 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1∐ Yes 3 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifie

Registrar

DHMH 17 Rev 1/2001

State

acks

28170 Old Village Road

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon W. Berube, M.D.

JAN 27 2010

31. Date filed (Month, Day,

D00506

Mechanicsville, MD 20659

January 26, 2010

# Maryland 21215-0036

and

P.O. Box 68760, Division of Vital Records,

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT VICTOR MERCER January 17, 2010 4:42 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Glade Valley Nursing & Rehabilitation Walkersville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Maryland 216-30-2819 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmet has notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Frederick Maryland Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 911 Pine Avenue 21701 U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 🕍 No Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Pharmacist Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor Grove Mercer Grace Feaga 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 911 Pine Avenue, Frederick, Maryland 21701 Eileen R. Mercer / Wife Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X remation 3 Removal from State 1/21/2010 Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License RÔBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 ens that caused the 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumani " /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 2 100 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1/ Natural 5 Pending investigation 1 □Yes 2 No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number -19-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Frederica Hemen shah. 1 homas 31. Date filed (Month, Day, Year) JAN 20 32. Registra State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

10-00792 Lewis Montgomery Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		- For State		Ce	ertificate	of i	Death					g. No. 2	$\Pi$	03252	
Physicia	Month  1. Decedent's Name (Pirst, Middle, Last)									Date of Deat Month	Day Y	ear	3. Time of Death 1842 hrs		
ledical Examin						1 45	c. City, To	wn orla	ocation of		January 27		y of Death		
		a. Facility Name (if not institution Calvert Memorial Hos		number)		40	Prince			Deau		Calver			
Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday	/)	If Under	1 Year	If Under		8. Date of Birt	h (MM/DD/YY		thplace (State or Foreign	
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		Usual Residence of Decedent													
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2121 buld be fill Mental B marked		19a. Informant's Name/Relations			19b. Ma	ailing	Address	(Street	and Numl	ber or Ru	ral Route Nun	mber, City or Town, State, Zip Code)			
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Baltimore, permit. Pages l and Department of Heal Important: If iten		D.O. Pour 600 Tursby MD 20657										:, F.A.	•		
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/Wedical	J	failure. List only one cause	e on each line.	licatio										Death	
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760, ficate be e g physician the burial	edi	IF FEMALE:		23a,F	PII,27,	,28	a-f	per l	ME g	900 2	2/1//10	23d. Date	of deliver	у	
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<b>—</b> ≈ ≈ 181	Ph	Part II. Other significant cond			ot resulting in	the u	nderlying	cause gi	ven in Pa	rt I.	23e. Did to	obacco use co	ntribute to	the cause of death?	
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ivision or Attend after death. Director:	atio	Pe	restigation 1/2	6/10 Place of Injury - A	unk	otro	at factors			-			mber or R	tural Route Number. City	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	de	termined (Spec	1		, siree	et, lactory	, onice bi	morng, et		Lusby,	State 605 MD	Merm	tural Routa Number, City	
Division of N To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral		4 Homicide  29a. Certifier 1 Contifuing	Physician: To the	best of my know	dedge death	occur	red at the	time, da	te and pla	ce, and	due to the cau	se(s) and mar	ner as sta	ated.	
To the H within 24 To the F complete	Medical	(Check only one) 2 Medical Ex	kaminer:On the ba	sis of examination	on and/or inve	estigat	tion, in my	opinion,	death oc	curred at	the time, date	and place, ar	nd due to t	he cause(s)	
<b>.</b> 5	Me	29b. Signature and title of certi		j.	1		290	. License	enumber					onth, Day, Year)	
		66	1 1	1/0				O.C.N	И.E.			January	28, 201	10	
		30. Name and address of person				لمرح	n C+	t Poli	more !	MD 242	201		. ——		
		Zabiullah Ali, M.D.	Assistant Me	edical Examin		ren	n Stree	i, baiti	more, f	VIU Z IZ	.01				
S Regis	tate trar		7 2010	Denewa.	d. x	Soa	went	5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12:00 PM **Physician** Ashby Nutwell Neil Jan 18. 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton 8804 Marquis Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 577-30-8394 82 Feb.15,1927 Washington DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evantation must be untilled at 1 ☐ Yes 🏋 No Clinton Director MD Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20735 8804 Marquis Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 2 □ No 1 Never Married 2 Married 1⊡Yes 2⊡yNo WWII Specify: à 3 ☐ Widowed 4 ☐ Divorced White 'natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Pump and Tank Mechanic Exxon USA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Spencer Nutwell Pat Joy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8804 Marquis Lane Clinton,MD 20735 Geneva Nutwell - Wife permit. Pages 1 a
Department of Hei
Important: If item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran's Jan.27,2010 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licensee mo1533 5 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Due to (or as a consequace of): **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 □Yes 2 □No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown r Kinsonis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home **XX** Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records,

within 72 hours after death

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i e Hospital or A 124 hours after e Funeral Dire

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🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 0111912010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rahimian, M.D 7501 Surratts Road, #205, Clinton, Maryland

31. Date filed (Month. JAN 2 U 2010 State Registrar

Medical

29a, Certifie

29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760 within 24 hours at To the Funeral D the Hospitei

drw 5

Registrar

31. Date filed (Month, Day, Year) JAN 2 1 2010 >

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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nolimatice

29b. Signature and title of certifier

K. Yazdani, MO

Solomon Is. Read. Huntingtown, m.D. 32. Registra s Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Donald William Medical Poffenberger Januar 2000 4a. Facility Name (if not institution, give street and number) Examiner 2:48 A M 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Social Security Number **Funeral** Washington 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 1 MM 2 DF 8. Date of Birth Director 219-66-1726 Birthplace (State or Foreign Country)
 Maryland Months Days Hours (Month, Day, Year) Min. 54 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified as 10a State 10b. County Funeral Director 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Hagerstown 10e. Street and Number 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 304 N. Mulberry St. 21740 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Baltimore, Maryland 21215-0036 þ 1 Never Married 2 Married 14. Race - American Indian, Yes 2 No Yes, Give Black, White, etc. Completed 3 Widowed 4 Divorced 1 ☐ Yes 2 No Specify. Year or Dates 15. Decedent's Education (Specify only highest grade completed) White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be Finisher 17. Father's Name (First, Middle, Last) Construction 18. Mother's Name (First, Middle, Maiden Surname) Garrett Hait Poffenberger Fannie Louise Burger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kathy S. Merchant / Friend</u> Mulberry St. Hagerstown Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Smithsburg Crematory 1/30/2010 21. Si wure of Funeral Service Licentee Smithsburg Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Approximate Interval Between Onset and Death HERRAC Medical Examiner Sequentially list conditions, if any leading to innectate cause. Enter Underlying Cause (Disease or iinjury that initiated events enone enc Examine bue to or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Yes 2 9 Unknown 9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? DancraTiTIS 2 No 3 ☐ Probably 4 ☐ Unknown ate has bage 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Moperinis autopsy performed' 25. Was case referred to medical Be 2 No 1 Tyes 26. Place of Death (Check only one) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner Death

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Physician: "
within 24 hours after death.
To the Funeral Director: After this certifics completed filled in by the funeral director; r

Medical

State

Registrar DHMH 17 Rev 7/2009

Other: 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 28d. Describe how injury occurred Accident Investigation 1 Yes 6 Could not be Suicide 4 Homicide determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Magerstown

muca X Juesell 1006111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 AnTIETam

Francisco 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Daniels

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ eters Year 5:25 AM Mortimer lan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Universit Baltimore Maryland Medical N/A . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) NOV 1 1959 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Min. 1**X** M 2 □ F Hours Country) **Director** 220-78-4053 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland N/A Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 USA 4134 Duane Ave Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or 1X Never Married 2 Married Š Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Associate Walmart Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Mortinan Peters Mary Freeland permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mortinan Peters (Father) Stoney Hill Ct. Odenton, Md. 21113 523 Baltimore, 20a. Method of Disposition 20b. Hace of Disposition (dame of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens | 1 - 21 - 10Annapolis, Md. WIMame aRamseof ScilitSons Mortuary, 21. Signature of Funeral Service License Md. 21401 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Meumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Po Month Pregnant at time of death signed by the a 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s After this certificate has autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 1 No မ 1 Tyes 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) sar 1710112602 2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St. Baltimore MO

State Registrar

31. Date filed (Month, Day, Year)
JAN 2 0 2010

parke

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Jan Physician 2 0°1°0 Fred W. Poindexter 4:30p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Laurel Prince George's Cherry Lane Nursing Center If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Davs 578 48 1229 Director 79 April21,1930 Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a State the Medical Examiner must be notified at 1 □Yes 2 □ No Director 28a-f Washington DC 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 733 Adrian Street SE 20019 Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after ty⊒Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 ➡ No 1950-52 Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Cook permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other tra Walter Reed 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George POindexter Margaret Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Poindexter/son 7603 Zenith Way Clinton, MD 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. 4 ☐ Donation 5 ☐ Other (Specify) 1-15-10 | Brentwood, MD Lincoln Cem 21. Signature of Funeral Service I 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Cancer unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar discounting Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed and Due to (or as a consequence of) burial Box 68760. physician Physician/Medical the attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen ( 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? Yes 2 No this certificate 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

Le Funeral Director; A

bletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BB481VA 62 ON 2 5 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Harold Russel Perrin January 12:05 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charles 31 Fairmont Place Indian Head Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 **X** M 2 □ F Pennsylvania 301-09-2296 ∜918 91 Director Usual Residence of Decedent shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other trainmants. Funeral 31 Fairmont Place 20640 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self Employed Florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ada Swartzwelder Floyd R. Perrin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances P. Moody Daughter Box 57, Cobb Island, Md. 20625 P.O. 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 20a. Method of Disposition 20c. Location - City or Town, State 25<sup>Date</sup> 2010 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral Service Name and Address of Facility Williams Funeral Home, 4270 Hawthorne Rd., In M00668 Indian Head, Md. 20640 23a. Part 1. Enter the or complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart e. List only one cause on ea Immediate Cause (Final Onset and Death M SONI Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events One to for as a consectioner of burlal-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of). resulting in death) Last attending physiclan for use as the burlal Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Yes 2 No ed by the a detached f 9 Unknown g Unknown of Vital Records, P.O. signed t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? Division 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person-

JAN 2 2 2010

DHMH 17 Rev 7/2009

acke

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

0

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ JANUARY PAUL BLAGDON RHOADS 2010 2:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 17,1920 Maryland Months 1X□ M 2 □ Days Hours Min Director 217-12-1218 89 Usual Residence of Decedent shov 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c, City, Town or Location be notified at Directo 28a-f 1 Yes 2 No Maryland Frederick Frederick ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral er than "natural", or items 23a the Medical Examiner must be 125 West Church Street 21701 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify 3 XWidowed 4 Divorced 1947 Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) +4 Microbiologist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Paul B. Rhoads, Sr. Louise Schly t. Page 1 and 2 should be trment of Health and Mer rant: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 W. Church St., Frederick, MD 21702 Mary E. Garner McHenry/Daughte t: If item 2 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 XCremation 3 Removal from State Stauffer Crematory 1/20/2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal e of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 Rand 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysiciani Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 🗆 No 1 Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one . Signature and title 29d. Date signed (Month, Day, Year)

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State Registrar 30. Name and address of perse

JAN 21

31. Date filed (Month, Day,

arks

pleted cause of death (Item 23a) (Type, Print)

r's Signature

		_ 1	For State	State of Mar		artment of H tificate of D		Mental Hygier Reg.	2011	03260
			Registrar  1. Decedent's Name (First, Middle, Last)		00,	imodeo or B		2. Date of Death		3. Time of Death
	Physicia Medic	al .			ONEY			Month /	Pay 20/0	
-	Examin	er	la. Facility Name (if not institution, give st			4b. City, Town, or Annapoli	Location of Death		4c. County of Dear Anne Aru:	
	Funeral		Anne Arundel Medic  5. Social Security Number   6. Sex	7. Age (/	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g. Bir	thplace (State or Foreign
	Director		033-14-3409	M <sup>2 □ F</sup> 84	Yrs.	Months Days	Hours Min.	11/22/19	$\frac{6}{25}$ Mas	sachusetts
	nd <b>how</b>		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Loc	cation				10d. Inside City Limits
	daryla 8a-f s tified	Director	Maryland Anne Arun	del	Annapolis					1 ☐ Yes 2 🛣 No
	h the had a or 2 be no	a D	10e. Street and Number	200		10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath wit	Funeral	805 Coxswain Way A	2. Was Decedent Eve	erin IIS 13 V	21401 Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian
9	ter dez or ite	by Fi	1 Never Married 2 X Married	Armed Forces? 1 X Yes 2 □ No	19//-	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
003	ours af tural"; al Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1946				Specify: Wh:	
75	n 72 ho an "na Medic	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)		(Give I	lent's Usual Occupa kind of work done d D NOT use retired)	uring most of work	ing 16t	o. Kind of Business	Industry
212	withir giene ner tha	C. Police	e Dept.							
and	ntal Hy ed oth	en Surname)								
aryli	ould bud Me and Me and Me and Me and Me and Me and Me	or Town, State, Zi	p Code)							
ž	nd 2 sh salth a n 27 is er tra		Hiltrud S. Rooney/V	Vife	805 (	Coxswain	Way Apt.	209 Annap	olis, MD	. 21401
ore	ge 1 ar t of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F	Removal from State		natory or other place	e) ;		. Location - City or	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signatur Funeral Service Licensee		Kalas Cre			0/2010   Ed orge P. Ka	gewater, las Funei	
Ba	permit Depar Impor any in		Jan Chan	as of				nd Rd. Edg		
			23a. Part 1. Enter the disease, o complishock, or heart failure. List only one	cause on each line.		10 2002				Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	RESP	RATORY	FAILU	RE AC	UTE		2 D
34-17-2	Examiner		Toolang in asaan	Due to (or as a c	CONSEQUENCE OF):	ASKIRAT	TINU PN	EUMONIA		L WL
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		consequence of):					
	ecuted and -transit	xam	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
0	ate be executed oblysician and the burial-transit	dical Examiner	Tooling in death, East	1						
8760	death certificate be executed ne attending physician and ed for use as the burial-transit	Medi	IF FEMALE:							
Box 687	hat the death certific ed by the attending p detached for use as	_	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
	he dea y the a ched f	hysic	1 🗌 Yes 2 🔲 No 9 🗍 Unknown	9 Unknown	ine or death 5 L	Uner (specify)				
P.O.		by PI	Part II. Other significant conditions con	tributing to death but	not resulting in the υ	inderlying cause giv	en in Part I.			o the cause of death?
Division of Vital Records,	Physician: The law requires this certificate has been sign ral director, page 2 should be	eted								Probably 4 Unknown
oce	has b	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
E E	sician: The certificate rector, pag	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Chec	1 Yes 2 k	No 1 Ye	s 2 No
Vit.	Physicia this cer al direct	70 B	1 LI Yes 2 M No		t 2 ER/Outpatier		er: 4 🗌 Nursing H	ome 5 Residence	e 6 Other (Spe	cify)
n of	Jing Pl h. After tl funera	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		work	≀at ? Yes 2 □ No	28d. Describe how in	njury occurred	
Siol	l or Attending after death. Director; After I in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	/ - At home, farm, str		103 2 1110	28f. Location (Street		ural Route Number,
Div	ital or irs afte al Dire		/	building, etc.	(Ѕресіту)		h	City or Town, S	rate)	
	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical		er: On the basis of exa	mination and/or inves	tigation, in my opinio	n, death occurred a	t the time, date and p	ace, and due to the	cause(s) and manner stated.
	To the Hospital within 24 hours a To the Funeral Completed filled	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	1 / actioner. To the be	T L	29c. License			Date signed (Mon	
	,		micho	1 V 05	Luta M		L1438		annay.	192016
-	THAT		30. Name and address of person who co	hypleted cause of dea	ath (Item 23a) (Type, F	( DEREA	LE HIBI	HWAY AA	JURACIS	MD 21401
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	barker	11101			
	Registr	ar	JAN 2 0 20	110 Dener	~ 1. 14					

		For	artment of Health and Mental Hygiene	
		Toglowa!	rtificate of Death Reg. No. 2000 32	6
Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Dorothy Ellen Ruley	2. Date of Death Month Day Year Jan 15, 2010 1:22PM	
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death	
A.		2303 Pinefield Road	Waldorf Charles	
Funeral Director	Н	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  577 42 4113 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or House)   9. Birthplace (State o	Foreigr
		Usual Residence of Decedent		
larylan show	5	10a. State 10b. County 10c. City, Town or Lo		
the M 28a-f	rect	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	121.10
h with	Funeral Director	2303 Pinefield Road	20601 United States	
ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be rediffied at once.	by Fu	1 Never Married 2 Married 1 TYes 2 TNo	1 □Yes 2 □ No Specify: Specify: White	
2 hour		15. Decedent's Education 16a, Dece	edent's Usual Occupation 16b. Kind of Business/Industry	
thin 7%	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	
ed wit ygien rer th t, the	S	6th M	Meat Department Safeway	
be fill the out	Be c	17. Father's Name ( <i>First, Middl</i> e, <i>Last)</i> UNKNOWN	18. Mother's Name (First, Middle, Maiden Surname)  Nellie Elizabeth Smith	
should nd Me mark imatic	٩		ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 salth a			303 Pinefield Road, Waldorf, MD 20601	
Pages 1 and of He Int: If Item		20a. Method of Disposition  1 Burlal 2 Cremation 3 Removal from State	osition (Name of material place) Jan 19,2010 20c. Location - City or Town, State	-
t. Pag rtment rtant:		4 □ Donation 5 □ Other (Specify)   Trinity	Memorial Gardens Waldorf, Maryland	
Depa Impo			2. Name and Address of FacilityLee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735	
6		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	Interval Between	en
Physician		Immediate Cause (Final disease or condition	Onset and De	ath
/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
	řer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
cate be executed physician and the burial-transit		resulting in death) Last  Due to (or as a consequence of):		
	dical	d		
eath certifii attending f	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery	
Attending Physician: The law requires that the death certific redeath.  actor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	sician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy Month Day Ye ☐ Other (specify)	ar
that the de	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dea	ath?
w requires the speed signer should be consigner.	d by	Tarch. Other significant conditions contributing to death but not resulting in the c	1 Yes 2 No 3 Probably 4	
w req	lete		24a. Was an 24b. Were autopsy findings av	ailable
The lav	Completed		autopsy prior to completion of cau death? 1 □ Yes 2 □ No	ise of
Ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
ding Physician.  After this certific funeral director,	ဥ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	E constitution of the cons	
ding F h. After funera	tion:	27. Magner of Death  28a. Date of Injury (Month, Day, Year)  2 \( \triangle	of 28c. Injury at 28d. Describe how injury occurred Work?  M 1 □ Yes 2 □ No	
Attendir death.	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office 28f. Location (Street and Number or Rural Route Number	9 <i>r</i> ,
tal or rs afte al Dir	Certification:	Turnormiciae building, etc. (Specify)	City or Town, State)	
To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) and manner stated.	th occurred at the time, date and place, and due to the cause(s) and manner as stated. nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
		▶ KYEU ~	102831 5 1-19-10	
RRM		30. Name and address of person who completed cause of death (Item 23a) (Type,		
Sta	ate	31. Date filed (Month, Day, Year) 32/ Registrar's Signature	ngton Road, Suite 102, Waldorf, MD 20602	
Regist		JAN 2 1 2010 Cerus A. Sa	e del	

			For State Registrar		State o	f Mary	land / Dر) )	•	ent of l ate of			lental H	gien/ Reg. N	61	010	0	326
	ysicia		1. Decedent's Nam	ore Sny	,							2. Date of D Month	eath D	ay	Year 2010		of Death
	Medic camin				give street and nui	mber)		4b.	City, Town, o	or Location	of Death	LUMNUAI		c. County			<u> </u>
			Reeder's		al Home				onsbo					Wash:	ingt	or.	
	neral ector		5. Social Security N 219-12-1	326	6. Sex 1 X M 2 □ F	7. Age (II	n yrs. last birth 89	rs. Mor	ths Days		Min.	8. Date of B (Month, D April	<i>lay, Yeal</i>	920	9. Birth Cou	place (Stat ntry) MD	e or Foreign
and	-23		Usual Residence o	10b. County		10	c. City, Town	or Location								10d. Inside	City Limits
ne Maryl	notified at	ector	MD	Washir	igton		Boonsb										es 2□No
, with	2	ä	10e. Street and Nu						Zip Code					Citizen of V	What Cou	ntry?	
0036 nours after death w	2 E	era	141 S.  11. Marital Status	Main S	12. Was Dece	edent Ever	r in U.S.		21713 ecedent of	Hispanic C	Origin? (Sp	ecify Yes or N	USA o-		e - Amer	can Indian,	
215-0036 thin 72 hours after death with the Maryland	Examiner	Completed by Funeral Director		ried 2 Marri	Armed Fo 1 ∐Yes If Yes, Gi Year or D	2 No ve No			specify Cub s 2√2 No			ecify Yes or N Rican, etc.)		Specify	ck, White, v: Wi	etc.	
5-0 72 ho	lical	eted	/Sne	15. Decedent	s Education t grade completed)		16a. [	Decedent's	Usual Occu f work done	pation	act of work	ina	16b.	Kind of Bu			
2121 ad within ygiene.	t'ne Mac	omple	Elementary/Seco		College (1	-4or 5+)		ife. DO N	T use retire	ed)	ost of work	ii ig	Ag	ricul	lture	<u>.</u>	
Maryland d 2 should be filed the and Mental Hy	vent,	Be C	17. Father's Name	(First, Middle, L	.ast)					18. Mot	her's Nam	e (First, Middl	e, Maide	n Surnan	ne)		
Vial Ment	atic e	2	Guy Sny	yder, Si	r.					B1a	nche	Mann					
2 sho	ing		19a. Informant's N					•	,			al Route Num			State, Zi	p Code)	
and leafth	hert				iece-in-l					Lane		cock,M			Oit T	Ctata	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene.	jury or of				3 □ Removal from ecify)	State	20b. Place of E cemetery, Stone E	crematory Bridge	or other pla	tery	01/2		Han	cock.	,MD	own, State	
Bal permit Depar	any ir		21. Signature of F	uneral Service t	V	202	60		e and Addr		. т	41 West P.A.Ha					368
Physi	cian		Immediate Cause disease or condition	(Final on	complications that conly one cause on e	aused the ach line.	iA.	et enter the		in <b>g,</b> such a	as cardiac	or respiratory	arrest,			Approxing Interval E Onset an	nd Death
/Med Exam			resulting in death)		A	(or as a co	onsequence of	):								YEAR	
pe	sit	iner	Sequentially list confidence in any, leading to in cause. Enter Under Cause (Disease on that initiated event	onditions, inneulate erlying	Due to	or as a co	onsequence of	j.							- 10	1 V-n	,
8760, 4-cate be executed obvisician and	the burial-transit	dical Examiner	that initiated event resulting in death)	Last	U	(or as a co	i D onsequence of	MTRIV ):	<u> </u>							1-704	K.
687 rtificate		/ledio	IE EENAL E					-									
ords, F.O. box or requires that the death certification is the attending.	hed for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	2 months? □ No		birth 2 ☐ nant at tirr	oregnancy Fetal death ne of death		oic pregnan r (specify) <sub>-</sub>	су					te of deliventh	very Day	Year
quires that t	pe q	þ	Part II. Other signi	ificant conditio	ns contributing to de	eath but no	ot resulting in t	he underly	ng cause gi	ven in Parl	t I.			use cont		the cause of	of death?
	page 2 should	Completed										24a. Wa aut per 1 □ Yes	opsy formed?		Were aut prior to c death? 1  Yes	opsy finding	gs available of cause of
of Vita Physician:	ctor, I	Be	25. Was case reference	rred to medical						26. Pla	ce of Deat	h (Check only			, 🗀 100	72.10	
T V hysic	Il dire		1 Yes 2√		Hospital:	Inpatient	2 ER/Outp	atient 3[	DOA		Nursing Ho	ome 5 Re	sidence	6 Oth	ner (Spec	ify)	
DIVISION OT VITAI RECORDS, all or Attending Physician: The law requires the after death.  Director: After this certificate has been sione	ne funera	Certification: To	27. Manner of Dea 1) Natural 2 Accident	5 ☐ Pending investiga	ation	of Injury th, Day, Ye	ear) 28b. Tii	me of ury M	28c. Inju Wo 1 [	ıryat rk? ⊡Yes 2[	□No	28d. Describe	how inj	ury occur	red		
UIVIS tal or Att	ed in by t	Certific	3 Suicide 4 Homicide	6	of be ned 28e. Place buildi	of Injury ng, etc. (S	- At home, farn Specify)	n, street, fa	ctory, office			28f. Location City or To			per or Rui	al Route N	lumber,
DIVISION Of VITAI HEC DIVISION OF VITAI HEC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	oletely fill	Medical (	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physician: To the examiner: On the b and man	best of masis of ex ner stated	amination and	death occi	rred at the tation, in my	time, date opinion, d	and place, eath occur	and due to the red at the time	e cause e, date a	(s) and m nd place,	anner as and due	stated. to the caus	e(s)
To the within 2	comp	ğ	29b. Signature and	title of certifier Ledu	1/				29c. Licen	se number	5)		29d. [	ate signe	d (Month	Day, Year	)
	n				vho completed caus					(0.)						0	•
	3		DR. GHAZ	ALA QAD	IR, 20311	LAP	PANS R	DAD,	300115	30RO,	MARY	LAND 2	1713	30	1-43	2 <b>-</b> 847	U
*	Stat		31. Date filed (Mor	nth, Day, Year)	▲   32. R	egistrar's	Signature										
DHMH 17 F	egistra		FEB (	5 2010	Beneval	A.	A COL										

DHMH 17 Rev 1/2001

ORIGINAL

10-00411 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  John Fletcher Riley Smith, Jr. State of Maryland / Department of Health and Mental Hygiene										
		1- For State Certificate of D.	eath	Reg. N	0. 2010	03263				
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)  John Fletcher Riley Smith, Jr.		of Death n Day ary 14, 2	y Year 010	3. Time of Death 1245 hrs				
			City, Town, or Location of Death Baltimore		4c. County of Death					
Funeral Director		214-42-1461	Months Dave Hours Min		M/DD/YYYY) 9. Birt Foreig Cou					
à		Usual Residence of Decedent		L 20,	1941 000					
nd show any ice.	٦	10a. State   10b. County   10c. City, Town or Location   Union Bridge	2			10d. Inside City Limits 1 Yes 2 XXNo				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 12509 Liberty Road	Of. Zip Code 21791	10 <b>g</b> . 0	itizen of What Coun	ntry?				
ath with items 23	uneral	1 Never Married 2 Married Armed Forces? If Yes,	ecedent of Hispanic Origin? ( Specify Ye specify Cuban, Mexican, Puerto Rican, e		14. Race - Americ White, etc.	can Indian, Black,				
s after de ral", or	by Fu	or Dates:	s 2 XX No specify:			white				
72 hours n "natui		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Uduring most	Jsual Occupation (Give kind of work done of working life, DO NOT use retired)	16b	. Kind of Business/Ir	ndustry				
5-0036 led within 7 Hygiene. l other than	Completed	8 Shop Po	18.Mother's Name (First, M	iddle. Maide	Automoti	ve				
1215, d be file fental Hy arked on vent, th	å	John Fletcher Riley Smith, Sr.	Pauline Bur	kett						
MD 21 d 2 should the and Mee nn 27 is man aumatic ev	리		dress (Street and Number or Rural Rou Liberty Road, Union							
more, I Pages I and ent of Heal ant: If item		20a. Method of Disposition  1	place)		c. Location - City or					
Baltim permit. Pag Department Important: injury or o	ŀ	4 Donation 5 Other Specify: Resthaven Me  21. Signature of Funeral Service Licensee 22. Nam			rederick, neral Hom					
m ឱ្ង≝≣ Physician	٥	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n	Opossumtown Pike,	Frede	rick, Mar	yland 2170: Approximate Interval				
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Ruptured Abdominal Aortic Aneurysm				Between Onset and Death				
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.								
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated C.								
ecuted and and transit		events resulting in death) Last Due to (or as a consequence of):  d.								
	edical	UNPENDED AMENDED								
Box 68760, e death certificate be the attending physic ed for use as the bur	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal of Pregnant at time of death 5 Others		2	23d. Date of delivery Month D	ay Year				
Box ne death the atter	hysici	1 Yes 2 No 9 Unknown 9 Unknown	(Specify)							
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician tuneral director, page 2 should be detached for use as the burial.	d by P	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I. 23e		o use contribute to t	he cause of death? ably 4 Unknown				
of Vital Records, ng Physician: The law require After this certificate has been si neral director, page 2 should b	ompleted		24a	Was an autopsy	prior to co	opsy findings available ompletion of cause of				
Rec n: The litticate h	ပေး	25. Was case referred to medical	1 ✓ 26.Place of Death (Check only one)	yes 2	? death? No 1 🗸 Yes	s 2 No				
F Vita	2 B	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3:	DOA Other Nursing Home		dence 6 Other:					
on of vending Physath.  or: After tithe funeral		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)	28c. Injury at Work? 28d. Des	cribe how i	njury occurred					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, fa		ation (Street own, State)	and Number or Run	al Route Number, City				
D To the Hospital Within 24 hours To the Funeral	ပြု	29a. Certifying Physician: To the best of my knowledge, death occurred								
To th To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.  29b. Signature and title of certifier	29c. License number		I. Date signed (Mon					
		Mas. v.	O.C.M.E.	Ja	nuary 15, 2010					
-1		Name and address of person who completed cause of death (Item 23a)     Ling Li, MD	Baltimore, MD 21201							
Sta Registi		31. Date filed (Month, Day Year) 2010 32. Registrar's Signature	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month Physician Suellen 10:47 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number mo If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🖾 F 9 Director 275-74-7035 Sept. 1965 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exa⇔iner rust be notified at 1 ∏Yes 2X No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 6852 Snowden Court 21703 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item in jury or other traumatic event, the Medical Examinations. 1 ∐Yes 21K No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ۵ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Theodore Stec Karen Sands 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6852 Snowden Court, Frederick, Maryland 21703 Craig Smith/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Inc. 1/17/2010 | Frederick, Maryland 21. Signatur Funeral Service 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Simplex Herpes /Medical Due to (or as a consequence o ): **Examiner** Marrow cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed Acute My Due to (or as a consequence of) and burial-trar Box 68760, attending physician certificate be Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2 1110 P.0. ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a, Was an autopsy perform this certificate 1 ☐Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 - No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA မ s after death. 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

To the within 2

State Registrar

Medical

29b. Signature and title of certifier

Martin Britos-Brau 31. Date filed (Month, Day, Year) 32. Registrar's Signature 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S GREENE S+ Boltimore, MD 21201

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 12:15p Steven V. Stone Sr. January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 4536 Timbery Drive Jefferson 8. Date of Birth (Month, Day, Year) Dec. 14, 1958 Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 X M 2 D F Months Davs Hours Min. Maryland Director 212-72-6080 Usual Residence of Decedent show 10h County 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 No Jefferson Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4536 Timbery Drive 21755 United States or items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give \$ and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natura!", 3 Widowed 4 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Paver Road Paving Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Maurice H. Stone Betty Mae Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, item 27 4536 Timbery Drive, Jefferson, Maryland 21755 Kathy M. Stone/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. . Page 1 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/2010 Frederick, Maryland. Olivet Cemetery 21. Signatur Juneral Service 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes P. A. Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician seconds Asystole ) Medical resulting in death) Due to (or as a consequence of) Examiner hours Hypoxia/Hypopnea/Acidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and the detached for use as the bunal-transit days Hepatic Encephalopathy that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be 124 hours after death.
 Funeral Director, After this certificate has been signed by the attending physicis weeks Hepatic Failure Division of Vital Records, P.O. Box 68760 IF FFMALE outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Metastatic Small Cell Lung Cancer 1 Yes 2 K No 3 Probably 4 Unknown Completed this certificate has been s ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Liver metastases autopsy performed? 1 Yes 2 No Yes 2 X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation the Suicide 6 Could not be To the Hospital or Atte within 24 hours after de:

To the Funeral Directol completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

DHMH 17 Rev 7/2009

State

3

31. Date filed (Month, Day, Year)

M.D.,

29b. Signature and title of certified

only one

Yun Oh,

MD

32. Registrar's Signature

Ceneura

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0067443

29d. Date signed (Month, Day, Year)

January 18, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

46 B Thomas Johnson Drive, Frederick, Maryland 21702

and

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1/1872010 **Physician** 0114 м Edward Schwartz /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. Cîty, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs\_last birthday) 77 Yrs. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□ F Months Days Hours Min 124-24-5446 ŃΥ Director 6/28/1932 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director MD Anne Arundel Annapolis 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with intent of Health and Mental Hyglene.

Intent of Health and Mental Hyglene.

Intent 27 is merked other than "natural", or items 23a or ury or other traumetic event, the Medical Examines must be to Funeral 3247 Harness Creek Rd. 21403 USA 12. Was Decedent Ever în U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: <u>م</u> 1 ☐ Yes 💥 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Electronics President 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Schwartz Ethel Auerbach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Creek Rd. Annapolis, MD 21403 Sandra Schwartz Spouse 3247 Harness 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Importent: If ite any Injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 1/20/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Rome, P.A. Annapolis, MD 21401 12 Ridgely Ave. ah 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a late of line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 10 TEN /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
2 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year slgned by the a 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 🗌 Yes 3 Probably 4 Unknown this certificate has been sail director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physicies: "within 24 hours after death,
To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?

Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of persu who completed cause of death (Item 23a) (Type, Print) CHY Medical Pkwy Annapolis, Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 21 2010

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James Dwight Snyder 12:03 P M 01/25/2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0akland Garrett Garrett Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1**√** M 2□ F Months Days Min. Hours 220-30-8543 Director 10/07/1935 74 MD Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examination must be notified 1 ☐ Yes 2 ▼No Director MD Garrett 0akland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 688 Mellott Road 21550 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2√□No Specify: lf Yes, Give Year or Dates: Specify.White <u>۾</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner Cabiret Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Snyder Ruth Mellott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Helen Snyder, Wife 688 Mellott Rd. Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maple Springs Cemetery1/29/2010 Eglon, WV 22. Name and Address of Facility David A. Burdock Funeral Home 21. Signature of Funeral Service Licensee 21 N. Second Street Oakland, MD 21550 Duecto Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each lige. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician minutes /Medical resulting in death) Due to (or as a consequence of): Examiner DERTENSION PERLIPIOREMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an ailucertificate has autopsy performed' 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Buczynski,

311 N. 4th Street, Suite 1, Oakland, MD 21550

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 8:35 PM January 22, 2010 Hazel Mildred Spangler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 836 Green Glade Road Garrett Swanton If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ F 90 01/17/1920 New Jersey Director 143-16-4150 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 23a or 28a-f show 1 ☐ Yes 2 No Director Swanton Garrett with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 826 Green Glade Road 21561 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Marken Exametre. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Trueland David W. Brand ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21561 Dorothy M. Gover 836 Green Glade Road, Swanton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Cumberland Crematory: 01/24/2010 | Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine Suring Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** WK /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Year Day Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 2 No 3 Probably 4 dinknown Completed cate has l certificate director, Be this Medical Certification: To funeral After

To the Hospital or Attending Physician; The law requires that the death certificate be executed ours after death. ieral Director: Af filled in by the fur 24 hours a within 24 hou

To the Fune

completely fi

									autopsy performed?		completion of ca	
25. Was case referred to n	nedical					26. P	lace of Dea	th (C	heck only one)			
examiner? 1∐ Yes 2√1Ño	Ho	ospital: 1   Inpatient 2	ER/Outpatient	3 🗆 D	OA Othe	4 [	Nursing H	ome	5 Residence 6	☐Other (Spe	cify)	
2 Accident	Pending investigation	28a. Date of injury (Month, Day, Year)	28b. Time of Injury	м	28c. Injury Work′ 1 □ Y	•	2 □ No	28d.	Describe how injury	occurred		
	Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street	, factor	y, office				Location (Street and City or Town, State)		ıral Route Numb	oer,
		ician: To the best of my kno										

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D23979

Tan 23,2010

30. Name and ad the f person who completed cause of death (Item 23a) (Type, Print)

311 N. 4th Street, Oakland, MD 21550 Robert A. Goralski, MD

State Registrar 31. Date filed (Month, Day, Year) 32. Registra s Signature 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2010 Month Physician/ Brown Smith 8:11 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore VA Medical Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Dec. 21 Country)
Maryland 1 🔯 M 2 🗆 F 82 213-24-7182 <sup>7</sup>1928 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Funeral Director MD. Baltimore Baltimore 1 🗌 Yes 2 😾 No 10f Zin Code 10e Street and Number 10g. Citizen of What Country? ō ral", or items 23a or Examiner must be 21237 United States 8545 Pulaski Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian ed Forces? Yes 2 \( \sum \) No \( \www. \) \( \www. \) Black, White, etc. þ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: white "natural" Completed 3XXWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Freight Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Smith Mary Elsie Ritchie Loy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 88 Ambo Circle, Middle River, Maryland 21220 Richard Smith/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Westernport Maryland Philos Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Renal Cancer Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 🗌 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 ☐ Yes 2 ☐ No After this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗀 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year)

Registrar

or

State

Prafeena

31. Date filed (Month, Day, Year)

JAN 26

1336374321

10 N Greene Street Baltimore, MD

January

Bacchus, MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

	/Medic	al	Leon Matthew	Smith							January	20, 20	)10	7:30 a	
	Examin	er	4a. Facility Name (If not institution	n, give street and n	number)			4b. City, Town, o	r Location	of Death		4c. (	County of Dea	th	
			1040 Costers R	toad				Lusby				(	Calvert		
	Funeral		5. Social Security Number	6. Sex	7. Age (In )	rs. last birth	hday)	If Under 1 Year		24 Hrs. 8	B. Date of Birt (Month, Da	h Vear	9. Bir	thplace (State or Fore	ign
	Director		220-16-8039	1 <b>23</b> M 2□ F		82 Y	rs.	Months Days	Hours	Min.	May 11.			MD	
			Usual Residence of Decedent			0					ividy 1 1.			1110	_
	and		10a. State 10b. County		10c.	City, Town	or Loca	ation						10d. Inside City Lim	its
	sho	ō	140											1 □ Yes 2 □ 1	No
	Ba-f	ct	MD Calv	ert		Lusby		,							_
	should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Exprintmental be rectified at	Director	10e. Street and Number					10f. Zip Code				10g. Citiz	zen of What C	ountry?	
	3a d	] E	1040 Costers R	oad				20657				USA			
	ns 2	Funeral	11. Marital Status		cedent Ever in	n U.S.	13. W	as Decedent of H Yes, specify Cub	Hispanic Or	rigin? (Spec	ify Yes or No		14. Race - Am	erican Indian,	_
	iten Iten	٦	1 ☐ Never Married 2 Mar	Armed F			If '	Yes, specify Cub	an, M <i>e</i> xica	n, Puerto R	ican, etc.)		Black, Whit	e, etc.	
0000-0	or ', or	by	3 Widowed 4 Divorced	If Yes, C	Give		11	□Yes 2🗷 No	Specify	<i>'</i> :			Specify:	DII-	
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7	gien F #	ő	10					Pa	inter			Fed	eral Gov	ernment	
3	Hygent,		17. Father's Name (First, Middle,	Last)					18. Moth	er's Name (	(First, Middle,	Maiden :	Surname)		
7	l be	Be	Nathan Smith						Ann	ette Gr	rocc.				
Š	ould I Me nark	ဥ				100						01:		7. 0. 4.)	_
Mar	anc anc is m aum		19a. Informant's Name/Relations	ship (Type. Print)		1		Address (Street				er, City or	r Town, State,	Zíp Code)	
2	alth 27 3r tr		CoraLee E	E. Smith - w	vife		P.O	. Box 126	6, Lusl	by, MD	20657				
บ์	tem tem othe		20a. Method of Disposition	-	20	b. Place of	Disposi	ition (Name of atory or other pla		Da	ite	20c. Lo	cation - City o	Town, State	
2	nt or in or		1 Burial 2 ☐ Cremation		n State				i						
	tme tant jury		4 □ Donation 5 □ Other (5			St. Joh		M Church			26, 2010	Lusb	y, MD		
Dallilli	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinating in a bondfilled at once.		21. Signature of Funeral Service		0.0		22.	Name and Addre	ess of Facil	ity Sew	ell Funer	al Hon	ne, P.A.		
ם	82 = 29		Dladin G	sewel	90		.	1451 Dares	s Beacl	h Rd F	Prince Fr	ederio	k, MD 20	678	
			23a. Part 1. Enter the disease, o		-	leath. Do n								Approximate	
			shock, or heart failure. List					4	. ^ -		1 - 0		_	Interval Between Onset and Death	
€,	Physician		Immediate Cause (Final disease or condition	. 0	JOSU	VAR	4	ART	GK	4 1	115 E/	196			
	/Medical		resulting in death)		o (or as a con										
A.F.	Examiner														
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Š	ath o	an/	23b. Was decedent pregnant in the past 12 months?	1 Liv	e birth 2 🗌 I	etal death	3 □	Ectopic pregnan	су			2	23d. Date of do Month	Day Year	
	dea d fo	<u>:</u>	1 □Yes 2 □No	4 □ Pre 9 □ Un	egnant at time	of death	5 🗆	Other (specify) _					WOTH	Day 10a.	
	the	nys	9 ☐ Unknown	9 🗆 011	KIIOWII										
L	that led l	0	Part II. Other significant conditi	ions contributing to	death but not	resulting in	the und	derlying cause gi	ven in Part	I.	23e. Did t	obacco u	se contribute	o the cause of death?	?
2	sign Sign	þ	C. Laww	17 hein	IT ru	educ	6	und	sea	22	1 🗆	res 2	¬No 3□ F	robably 4 Unkno	wn
	edn	Completed	1	101	-	-/	· ·	7							
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Ĕ	he ha	Ē										rmed?	death?	completion of cause	OI
vital Records,	r. T										1 □ Yes	2 No	1 □ Ye	s 2□No	_
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	nysi dire	은	1 ☐ Yes 2 🙀 No	Hospital: 1 [	Inpatient :	2 🗆 ER/Out	tpatient	3 □ DOA Oti	her: 4□N	Nursing Hom	ne 5 Resi	dence (	6 □Other (Sp	ecify)	
5	g Pr er t eral	Ë	27. Manner of Death	28a. Da	te of Injury onth, Day, Yea	28b. T	ime of	28c. Inju Wo	iry at	2	8d. Describe	now injur	y occurred		
200	full Aff	ţ.	1 Natural 5 Pendii	ng (**** igation	onin, Day, rea	"	njury		Yes 2	No					
S)	To the Hospital or Attending Physician: The law requires that within 24 hours after death.  To the Funeral Director: After this certificate has been signed b completely filled in by the funeral director, page 2 should be detain.	Certification:	2 Accident Investi 3 Suicide 6 Could	not he	on of Injury	At home for	m otro				Of Location (	Stroot on	d Number or I	Rural Route Number,	_
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5	s af	Ç													
	nour ner ner y fill			ing Physician: To t											
	24 Fu Fu etel	Medical	(Check only 2 Medical one)	I Examiner: On the and ma	e basis of <i>e</i> xar anner stated.	nination and	d/or inv	estigation, in my	opinion, de	eath occurre	ed at the time,	date and	place, and di	e to the cause(s)	
	mpl #	Ne.	29b. Signature and title of certific	or.				29c Licen	se number			29d Dat	te signed (Mor	th. Dav. Year)	_
	<b>5</b> ≥ 5 0	_	29b. Signature and title of certific	- 1	120	7		200.	70	17	1	204. 54	1/5		
	- 41		In	war.					0,3	/ /		/	1/25	7/0	
	87)		30. Name and address of person	n who completed ca	use of death	(Item 23a) (	Type. P	Print)				,			
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DHI	MH 17 Rev 1/2	001													
							DIO	INTAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death Month

Day

			For State	State of N	Marylan		artment of H		and M	ental Hy	giene	)		
			Registrar  1. Decedent's Name (First, Middle,	l act)		Cer	tificate of E	eath)		2. Date of Dea	Reg. No	20	10	0327
	Physicia		_	Eug	ana	SI	ater			Month January	Da	У	Žear 2010	3. Time of Death 6:46 A M
	Medic Examin		Joseph 4a. Facility Name (if not institution, g			310	4b. City, Town, or	Location o		<u>arraar</u>	_	. County o	_	0.40 /1
	,		Stella Maris Nu	rsing Home	9		Timon	ium				Balti	more	?
	Funeral Director		5. Social Security Number 578-28-1496	5. Sex 1 🔀 M 2 🗆 F	Age (In yrs. Ia <b>94</b>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min,	8, Date of Birt (Month, Da <b>Jan .</b> 1	h 8, <sup>Year)</sup> <b>8, 1</b> 9	16	g. Birthpl Count Penn	ace (State or Foreign ry) <b>Sylvania</b>
	id now	ī	Usual Residence of Decedent  10a, State 10b, County		10c, Cit	y, Town or Loc	cation						110	d, Inside City Limits
	arylar a-fsl	Director	Manual and Dal	ti mana										1 ☐ Yes 2X☐ No
	or 28		Maryland Bala 10e, Street and Number	<u>timore</u>	1 1111	<u>nonium</u>	10f. Zip Code				10g, Cit	tizen of WI	hat Count	ry?
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	death item ner m	교	11. Marital Status	12. Was Deceden Armed Forces			Vas Decedent of Hi Yes, specify Cuba	spanic Orig n, Mexican	gin? (Spec	eify Yes or No- lican, etc.)		14. Race	- America , White, e	
9000	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	ted by	1 Never Married 2 Marrie 3 Widowed 4 🛭 Divorced	ed 1 Tyes 2 [ If yes, Give Year or Dates.	1946		☐ Yes 2 X No					Specify:		
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lary	should and M is ma		19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailin	g Address (Street a	and Numbe	r or Rural	Route Numbe	r, City or	Town, Sta	ate, Zip C	ode)
	and 2 s Health tem 27		Elizabeth J. Sil	ool/Niece			Tramore	Rd.						· •
Baltimore,	ge 1 a it of H		20a. Method of Disposition 1 🗡 Burial 2 🗆 Cremation		te Na	Place of Dispo cemetery, cren tion of	sition (Name of natory or other plac VIEMORIAI RK	e)		ate		ocation - (		
Ħ	permit. Page 1 s Department of H Important: If its any injury or ot		4 Donation 5 Other (Sp 21. Signature of Funeral Service Lice				. Name and Addres		2/2/2	2010	<u>Falls</u>			<u>, Virginia</u>
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587	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancv								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birti 4 Pregnan	h 2 ☐ Feta tat time of a	al death 3	Ectopic pregnanc Other (specify)	у				23d. Date Mon		ry Day Year
P.O. I	at the		9 Unknown  Part II. Other significant condition	L		sulting in the u	nderlying cause giv	en in Part I	l.	23e Did to	phacco i	ise contrib	oute to the	e cause of death?
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sior	ttend death stor: A	Certificate:	2 Accident Investiga 3 Suicide 6 Could n	ot be	niun/ - At he	ome form stre	M 1	Yes 2 🗌		Of Location &	troot on	d Number	or Pural	Route Number,
Division	al or A safter I Direct		4 ☐ Homicide determin		etc. (Specif)		oct, ractory, office			City or Tow			Or Murai i	noute Number,
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	the H hin 24 the F mplete	Me	only one) 3 🔀 Certifying I	Nurse Practioner: To the			leath occurred at the	e time, date			e cause(s	s) and man	ner as sta	ted.
	<b>5</b> ₩it		29b. Signature and title of certifier	. //	1	100	29c. License		7		29d. Da	te signed		
			30. Name and address of person w	ha completed cores of	f death (Item	1 23a) (Tupe D		760	LG			1/2	1100	010
			JENNIFER HAU				VALLEY RO	OAD	TIMOI	VIUM, M	D 21	1093		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	Back	9							

6:46 A.M.

JANUARY 27, 2010

JOSEPH SLATER

Amend AA Co	l #19a pe o. Health	r F De	un Dir 1-20-201 <b>6</b> lea ot lo	se Type or	<b>Print in I</b> of Marylan	Black II	ndelibl	e Inl	k. Ens	ure All	Copie	s Ar	e Legi	ble.	
		•	1 - For State Registrar	Otato	n wa yan		tificate			and Me	inai i iy	Reg. No	20	10	03271
		,	Decedent's Name (First, Middle)	, Last)							2. Date of De	eath			3. Time of Death
	Physicia Medi		Joseph V. Ty								Janua	ry	<sup>a</sup> 12 2	610	2227 м
1	Examir	ner	4a. Facility Name (if not institution Anne Arundel	Medica1	Cente		An	nap	Location o			_	c. County o	of Death <b>Aru</b> i	ndel
	Funeral Director		5. Social Security Number 217 – 26 – 4830	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. le	ast birthday) O Yrs.	If Under Months	1 Year Days	If Under Hours		B. Date of Bi uneth, D	rth 20 <sup>Yea</sup> 1	929		ce (State or Foreign yland
	aryland a-f show fied at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne	Arundel		y, Town or Lo !hurch								10d.	. Inside City Limits 1 ☐ Yes 2 🏋 No
	h the M 3a or 28 be not		10e. Street and Number				10f. Zip					10g. C		hat Country	
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9036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	ried Armed Fo			f Yes, specif				y Yes or No- can, etc.)			- American , White, etc. Blac	
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7	should be file and Mental F is marked o raumatic eve	-	Vernell Tyle:  19a. Informant's Name/Relationsh			10: 14:35					Crown				20722
	1 and 2 should be filed vor Health and Mental Hygitem 27 is marked othe other traumatic event,		Catherine Tyler(	Wife)							n Rd.			hton	9 20733 , Md.
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or otf		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		State Co	lace of Dispo emetery, cren rylan	natory or oth	er plac		Dat 1 - 1 9 -				Dity or Town	, State D, Md.
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	Physician/ Medical Examiner		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea	or as a consequ	1) 400	urdi	1	int	Gre	Tien			Int	pproximate terval Between nset and Death
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90	te be executed iysician and ne burial-transit	_ 1	that initiated events resulting in death) Last	C. Due to (	or as a consequ	ence of):									
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Euneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burning the filled in by the funeral director, page 2 should be detached for use as the burning the filled in by the funeral director, page 2 should be detached for use as the burning the filled in by the funeral director, page 2 should be detached for use as the burning the filled in by the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	come of pregnar Birth 2  Fetal nant at time of do	∣death 3 🗆	Ectopic production of the contract of the cont		у				23d. Date Mont	of delivery h Day	y Year
ds, P.O	quires that t an signed b uld be deta	ed by P	Part II. Other significant conditio	ns contributing to d	eath but not resu	ulting in the u	nderlying ca	use give	en in Part I	l.					ause of death?  y 4  Unknown
Division of Vital Records,	he law red ite has bed age 2 sho	omplet									24a. Was auto perfo	psy ormed?	pri de:	ere autopsy or to comple ath?	findings available etion of cause of
a	ian: T	Be C	25. Was case referred to medical examiner?		Ž.			26. Pla	ce of Deat	th (Check or		2 2 N	0 11		
Ĭ.	hysic this ce al direc	ပ္	1 ☐ Yes 2 ☑ No		Inpatient 2 - I		t 3 🗆 DOA	Othe	r: 4 □ Nu	ırsing Home	_5 🗌 Resid	dence 6	6 ☐ Other	(Specify)	
on of	ending Paath. or: After t	Certificate:	27. Manner of Death  1	ation	of injury h, Day, Year)	28b. Time of injury	M 280	work?	at Yes 2 🗆		f. Describe h	now injur	y occurred		
Divisi	ital or Atterns after de al Directo		3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e, Place	of Injury - At hor ng, etc. (Specify)	ne, farm, stre	et, factory,	office		28f	Location (S City or Tow			or Rural Rou	ite Number,
	he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 L Medical E	Physician: To the be xaminer: On the bas Nurse Practicings:	is of examination	and/or invest	igation, in my	opinios v	n, death oc	curred at the	time, date a	and place	and due to	the cause(s	s) and manner stated.
	vith Vith To t		29b. Signature and title of certifier	ande	170	)	29c.J	icense OC	number	445		29d. Dat	ite signed (/	Month, Day,	Year)
	9-1		30. Name and address of person v	SINDAIN	e of death (Item:	23a) (Type, P	rint)	P	VF	A	006	Dali	1, 1	(U	
	Stat Registra	e ir	JAN 20 20	10 Sens	egistrar's Signatu	bark	1	1000			,				

10-00739 Jennifer Taylor

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jennifer Taylor  Jennif	ryland side City Limits Yes 2 No an, Black, le) ate 1,MD 6 kimate Interval								
Civista Medical Center  La Plata  Charles  Charles  Civista Medical Center  La Plata  Charles  Charles  Charles  Country  Social Security Number  217-94-1056  1	ryland side City Limits Yes 2 No an, Black, le) ate 1,MD 6 kimate Interval								
Director    Director	ryland side City Limits Yes 2 No an, Black, le) ate 1,MD 6 kimate Interval								
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134 W. Quail Lane   20646   USA	ate  1,MD  6  kimate interval								
The part of the pa	ate  1,MD  6  kimate interval								
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of cemetery, 1 or Town, State, Zip Code of Disposition (Name of Cemetery, 1 or Town, State, Zip Code of Disposition (Name of Cemetery, 1 or Town, State, Zip Code of Disposition (Name of Cemetery, 1 or Town, State, Zip Code of Disposition (Name of Cemetery, 1 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Disposition (Name of Cemetery, 2 or Town, State, Zip Code of Dispositi	ate  1,MD  6  kimate Interval								
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20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, Since the place of Disposition (Name of Cemetery)  20c. Location - City or Town, Since the place of Disposition (Name of Cemetery)  20c. Location - City or Town, Since the place of Disposition (Name of Cemetery)  20c. Location - City or Town, Since the place of Disposition (Name of Cemetery)  20c. Location - C	1,MD								
21. Signature of Funeral Service Licensee M01458  22. Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sticinal cardiac or respiratory arrest. Shock or fleart failure. List only one cause on each line.  Examiner  23. Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A.  2064  Appropriate Cause (Final disease as Acute bronchopneumonia	1,MD								
21. Signature of Funeral Service Licensee M01458  22. Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A.  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sticinal cardiac or respiratory arrest. Shock or fleart failure. List only one cause on each line.  Examiner  23. Name and Address of Facility AREHART—ECHOLS FUNERAL HOME, P.A.  2064  Appropriate Cause (Final disease as Acute bronchopneumonia	6 ximate Interval								
Physician  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Examiner  Immediate Cause (Final disease a. Acute bronchopneumonia	ximate Interval								
failure. List only one cause on each line.  Between Examiner Immediate Cause (Final disease a. Acute bronchopneumonia									
	en Onset and Death								
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Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	-								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Multiple blunt force injuries  Due to (or as a consequence of):									
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AMENDED AMENDED PI line a-c, 27,28a-f,permE, g901 3/4/10 TT  23d. Date of delivery									
Constitution of the position o	Year								
So was decent pregnant in the past 12 months?    1									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	of death?								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca									
24a. Was an autopsy find part of the part									
The state of Death (Check only one)  25. Was case referred to medical examiner?  Wes 2 No 1 Ves 2 N	2 No								
Solution in the state of the st									
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred passenger pick—up									
Natural   Suicide   Natural   Natural   Suicide   Natural   Natural   Natural   Suicide   Natural   Natu	) (u								
See 5 > 29a Certifier	a, MD								
3 Suicide 6 Could not be determined (Specify) street 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) W/B MD Rt. 22 Ripley Park Dr. LaPlat (Specify) street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) W/B MD Rt. 22 Ripley Park Dr. LaPlat (Check only one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier 29d. Date signed (Month, Dav.)	)								
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,	'ear)								
30. Name and address of person who completed cause of death (Item 23a)									
Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature, Registrar									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Touster Arlene 2010 Medical January 6:15 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18003 Mateny Road Germantown Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) New York 1 🗆 M 2 🖾 F Dec 31, Year) Months Days Hours Director 73 091-30-0784 Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c, City, Town or Location Director 10d. Inside City Limits 1 Tes 2 No Maryland Montgomery Germantown 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18003 Mateny Road #217 United States death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Completed White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmission. Elementary/Seconday (0-12) College (1-4 or 5+) Manager Bowling Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Solomon Goldman **Yvette** Heit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen Touster/husband 18003 Mateny Road #217 Germantown, Maryland 20874 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 1/20/2010 Woodbine, Maryland 21. Signa re of Funeral Service Licen <sup>22. Name and Address of Facility</sup>
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Pancreas Cancer years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death Month the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? pade perform Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🔀 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 1 🗌 Yes 2 🗀 No s after death. Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my threwledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45880 January 19, 2010

DHMH 17 Rev 7/2009

State

Registrar

Rockville, Maryland 20850

1396 Piccard Drive

32 Registrar's Signature

Execution

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon C. Hwang, M.D.

31. Date filed (Month Pax)

10-00720 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Joseph Trice State of Maryland / Department of Health and Mental Hygiene 2010 03275 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month **Medical Examiner** 0647 hrs William January 25, 2010 Joseph Trice 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel County Detention Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director Months Days Hours 220-86-6495 07/25/1961 1X M 2 F 48 Country) Maryland Usual Residence of Decedent Ę 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Descrimore, MD 21215-0036

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other them. California Maryland St. Mary's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23841 Three Notch Road 20619 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 1 X Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify. 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Towing Company 11 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Trice, Sr. Edith Boothe ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23841 Three Notch Rd., California, MD 20619 Suzzanne M. Trice/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 01/29/2010 Charlotte Hall, MD Brinsfield-Echols Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Kyle S. Simons M012 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Hanging Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 Pregnant at time of death Other (Specify) ned by the atte detached for t 1 Yes 2 No 9 Unknown 9 Unknown signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed icate has been si page 2 should b 24a. Was an 24b Were autopsy findings available prior to completion of cause of autopsy performed death? ✓ Yes 2 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) director Be Other<sub>4</sub> ER/Outpatient 3 DOA Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 🗸 Yes ٩ No funeral 28a. Date of Injury (Month, Day Year) FOUND: 27 Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 \_\_ Natural Subject hanged self FOUND 5 Pending 1 Yes 2 ✔ No the in 24 hour.
the Funeral Director filled in by the Jan 25, 2010 0621 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State)
Anne Arundel Co Detention Center, Annapolis, MD determined (Specify) Jail/Penal 4 \_\_\_ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 To the I 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. January 26, 2010 30. Name and address of person who completed cause of death (Item 23a) Hene Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar IAN 29 ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and Mental Hygiene														
			1 - State Registrar Certificate of Death Reg. No [ ]												03	276
			1. Decedent's Name (First, Middle, La	st)							2. Date of De		ay	Year	3. Time	of Death
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and a	Examir		4a. Facility Name (If not institution, given	e street and numbe	er)		4b. City, T	own, or	Location o	of Death		4	c. County o	f Death		
and the			Garrett County G					land				1	Garret			
	Funeral		Social Security Number     6. 8	Sex 7. A ▼ M 2 □ F	Age (In yrs. la	ast birthday) Yrs.	If Under	Days	If Under:	Min.	8. Date of Bird (Month, Da	th iy, Yea	(r)	Cour	lace (Stat ntry)	e or Foreign
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	Mary -f sh	ţō	MD Garret	÷	0.21	kland									1 □ Y	es 2∭No
	r 28a	irec	10e. Street and Number		Odi	KILGIIG.	10f. Zip	Code				10g. (	Citizen of Wh	nat Cour	ntry?	
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an	ental ental ked c	To Be	Charles E. Teets						Mary	v Tri	ckett					
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	and 2 ealth a n 27 is		Sharon Teets, Wi	fe		1557	Sand	ers	Lane	, Oak	land,	MD	21550			
e .	of He of He item		20a. Method of Disposition		20b. PI	ace of Dispo	sition (Nam	e of ner place	)	Di	ate	20c.	Location - C	City or To	wn, State	
Ē	Pages nent of i		1 ☐ Buria! 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.		e	nberla	-		i	01/27	/2010	C	umber.	land	, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lice	nsee			Name and	Addres	s of Facilit	v		1 H	lome.	Р. А.		
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п			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that daus one cause on each	ed the death line.	. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory a	rrest,			Approxin Interval E	nate Between nd Death /
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4	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ehce of):	-								1.7	
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	Funeral		5. Social Security Nu	ımber 6. Se	x 7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birth	place (State or Fore	eign
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36	ifter de ", or it amine	ρ	1 Never Marri		Armed Forces? 1   Yes 2 □ If Yes, Give	No	- 1	Yes, specify Cuba		Rican, etc.)		lack, White,		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation 3 ☐	Removal from State	cem	etery, crem	sition (Name of atory or other plac	e)		20c. Location	,	,	
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	the Ho thin 24 the Fu mplete	Med	only one) 3	Certifying Nurs	ner: On the basis of exe e Practioner: To the			eath occurred at the	e time, date and place	ce, and due to the	cause(s) and i	manner as st	ated.	stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen Addis Taylor 5:55 P<sup>M</sup> January 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Asbury-Solomons Health Care Center Solomons Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav. 9. Birthplace (State or Foreign Funeral Days 1 🗆 M 2 🔽 Hours 06/20/1914 Virginia **Director** 213-38-1766 95 Usual Residence of Deceden 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified Solomons MD Calvert 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11750 Asbury Circle, #232 20688 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Educator / Prince and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 George's Co. Schools School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Helen Isabella Roy Thomas English Addis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Helen A. Prince (Daughter) 2810 Allspice Road, Port Republic, Maryland 20676 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Damestown Presbyterian Church Cem. 1/25/2010 Darnestown, Maryland 21. Signature of Funeral Service Licenses Rausch Funeral Home, P.A. 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Failure to thrive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Dementia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Advanced Age and trar Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months? Por Month Day Year Pregnant at time of death Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗶 No 3 🗀 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? certificate 2 🗌 No Yes 2 X No 1 Yes Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2**X** No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending I 24 hours after death. 1 🔀 Natural 5 Pending thin 24 hours after death.

the Funeral Director: After management of the function of the func 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D58572 January 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gwyneth Blattau, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 21

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 19 2010 11:55 a. M Clara L. Weant Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14829 N. Franklinville Road Frederick Thurmont 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 2, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min 220-16-2443 ີ 1907 Director 102 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No Maryland Frederick Thurmont 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 14829 N. Franklinville Road Funeral 21788 **USA** death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2x No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: white "natural", 3 ▼ Widowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry ald be filed wrom. ...d Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. McGlaughlin Virginia Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14829 N. Franklinville Road, Thurmont, Maryland 21788 Oneida Hogan - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Blue Ridge Cemetery 1-22-2010 4 Donation 5 Other (Specify) Thurmont, Maryland 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death androvasculas Nisase Immediate Cause (Final Theroscieno 71 C Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner mantielly fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) Month Day Year ed by the a 9 Unknown signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00075152

Registrar

DHMH 17 Rev 7/2009

State

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32. Registraris Signature

Tros

Johnson Dr. Fredovek MD 21702

30. Name and address of persøn who completed cause of death (Item 23a) (Type, Print)

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RANTZ

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De 2. Date of Death Physician/ Day 8 2010 January 22:47 MM John Wagner Char1es Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Davidsonville 1560 Rossback Road 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1/13/1920 Mary Land Director 212-34-7889 90 Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🌠 No Davidsonville Anne Arundel Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1560 Rossback Road 21035 USA death v "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1942 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 1948 3 ▼ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Asphalt Plant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mathias Wagner Theresia Moritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1568 Rossback Rd. Davidsonville, Maryland 21035 Peter A. Wagner/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem'l Gardens 1/22/2010 Davidsonville, Maryland 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd. Edgewater, Maryland 21037 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sause on each line. 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Cardio vascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 🗌 Yes 2 No 3 Probably 4 Unknown cate has been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 2 X No 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00295 71 ense Hux, Crofton, MD 21114 225 32. Registrar's Signature State Registrar

State

Assistant Medical Examiner

Registra

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month Rey Year)

111 Penn Street, Baltimore, MD 21201

			For	State of N	/larylan		artment of H		Mental Hy			0.000
			Registrar  1. Decedent's Name (First, Middle,	Last)		Cei	Tillicate of t	Jean	2. Date of D	Reg. No	2010	3. Time of Death
	Physicia			IA ELIZABE	rh Wii	LIAMS			Month TANUAL	Day RY 20	Year 2010	12:45 A M
2.0	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	er)		4b. City, Town, or	Location of Dea			County of Dea	
			HARFORD MEMORIA					RE DE GE			HARI	
- 1	Funeral		5. Social Security Number 215–32–7284	5. Sex 7.7 1 □ M 2 🏋 F	Age ( <i>In yrs</i> . <b>70</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, D	irth Day, Year) 19	9. Bii C M	thplace (State or Foreign ountry)
	Director	1	Usual Residence of Decedent		70				JAN 25	19.	39 1	IARYLAND
	aryland show		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
1 -	e Mar	ctor	MARYLAND HAI	RFORD			HAVRE	DE GRAC	E			1 X Yes 2 No
5	ith th	Director	10e. Street and Number	3000000 AD	T) 4		10f. Zip Code	70			izen of What C	
170	death with the Maryland ms 23a or 28a-f show	Funeral	515 WARREN	12. Was Deceder		6 12 1	210		(Specify Vec or N	_	NITED S 14. Race - Am	
	after de or item	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>	Armed Forces d 1 □Yes 2	s?		Was Decedent of H If Yes, specify Cuba		erto Rican, etc.)	10-	Black, Whi	
036	hours a tural", o	l by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates	_		1 □Yes 2 📉 No	Specify:			Specify: B	LACK
5-0	72 ho	Completed by	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done of	during most of w	orking	16b. K	ind of Business	/Industry
121	vithin ene. than "	ldm	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retired BARTENDER	1)			VFW	
d 2	filed v Hygie Ither I		17. Father's Name (First, Middle, Li	l ast)				18. Mother's Na	ame (First, Middle	e, Maiden		
lan	ld be lental ked c	To Be	WALTER KENLEY					VIRGINI	A REED			
$\langle C \rangle$ aryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mential Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Medical Examinations to confine I and it and it is the medical at	-	19a. Informant's Name/Relationshi	p (Type. Print)	20110	19b. Mailir	ng Address (Street	and Number or I	Rural Route Num	ber, City o	or Town, State,	Zip Code)
Σ.	1 and 2 Health em 27 i		MELISSA D. JENI	KINS/GRANDI	DAUGHI	P.O.	BOX 14216	6, NEWPO		7		
1/2C	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3	B □ Removal from Sta	te C	cemetery, crer	sition (Name of matory or other plac	1	Date	20c. Lo	ocation - City or	r Town, State
Ţ, Ē	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Spe	ecify)	R A		s & co, :		27/10	WE	ST CHES	STER, PA
Bal	permit. Departr Importa any Inju		21. Signature of Funeral Service Li	censee	2	. 2	2. Name and Addres	OTT FUNE	RAL HOME	Ξ, Ρ.	Α	01000
0		0 9	23a. Part 1. Enter the disease, or c	omplications that caus	ed the deat	h. Do not ent					GRACE,	MD 21078 Approximate Interval Between
A.	Physician		shock, or heart failure. List of Immediate Cause (Final	nly one cause on each	line.	PD						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a	as a conseq	uence of):						
1524	Examiner		Sequentially list conditions.	b								
7	ted is it	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events	Due to (or a	as a conseq	uence of):						
1 - 6	sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):						
0928	certificate be executed triing physician and se as the burial-transit	dical E		d								
77.89	rtificate ng phys as the	Nedi	IF FEMALE:									
30X		Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	n 2 🗀 Feta	al death 3 [	Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year
0	he deg	/sici	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnan 9 ☐ Unknowi		death 5 [	Other (specify)					22,
> 4.	The law requires that the death ate has been signed by the atterbage 2 should be detached for u		Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	i tobacco i	use contribute	to the cause of death?
ds	uires n sign ld be	d by							_   ₁)⊠	Yes 2	□ No 3 □ F	robably 4 🗌 Unknown
) Score	s bee	Completed							24a. Wa		24b. Were a	utopsy findings available
<u> </u>	The law ate has bage 2 s	E O		. <u>.</u> <u>–</u>					- auto per 1 □ Yes	opsy formed? 2 <b>X</b> No	death?	completion of cause of s 2 □ No
 ✓ Vital	<b>hysician:</b> The le his certificate ha I director, page 2	Be C	25. Was case referred to medical examiner?					26. Place of D	eath (Check only		1010	0 22.110
_ 5	hysic this co	၉	1 Yes 2 No			ER/Outpatie		4 🗀 Nursing	Home 5 ☐ Res			ecify)
	ling P	jon:	27. Manner of Death  1 Natural 5 ☐ Pending		njury D <i>ay, Year)</i>	28b. Time o Injury	Worl	yat k? Yes 2 ∐ No	28d. Describe	e how inju	ry occurred	
Division	death ctor: y the	Certification:	2 Accident investiga 3 Suicide 6 Could no	t be lass of	Iniury - At h	 ome. farm. str	reet, factory, office	res Z 🔲 NU	28f. Location	(Street ar	nd Number or F	Rural Route Number,
<u>~</u> ≥	after after Direct	erti	4 ☐ Homicide determin	building,	etc. (Speci	fy)	,,		City or To	own, State	9)	,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.			Physician: To the be								
	the Hi nin 24 the Fu	Medical	one)	xaminer: On the basis and manner		alion and/or ir			curred at the time	-		
	Vitt Con	2	29b. Signature and title of certifier				29c. Licens				ite signed (Mor	
	1.1			M.D		00 1 0	VO	06348	l	1/2	20/20	10
	71		Benjamin Lee.		_	n 23a) (Type, Ation S	7 Hav	re de C	rpace,	MD	21078	<b>&gt;</b>
	Sta	te	31. Data(len/Moths Day Year)		strar's Signa			000	,,	<u> </u>	10	
	Pagietr	ar	AULT DO TOTAL	Bearing .	A A							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Donald L Walters Jan 24 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Oakland Nursing & Rehab 0akland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min 1 ☑ M 2 □ F Director 220 34 1274 MD 7-26-1938 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ns 23a or 28a-f show must be notified at 1 √Yes 2 No Director MD Allegany Cumberland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 ann of Health and Mental Hygiene. arter 16 Health and Mental Hygiene. The marked other than "natural", or items 23a or 1 and 1 11 Bellevue Street 21502 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █️No 14 Race - American Indian 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elva Frances Grogg ည Howard William Walters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troone. Nancy Gorsuch, Sister 29 Sunset Drive, Springfield, OH 45504 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 01/26/2010 Cumberland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licenses Katherine 21 N. Second St., Oakland, MD 21550 DURINA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician not. disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ♠No 24a. Was an 1 ☐ Yes 2 Atolo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s

> State Registrar

Medical

29a. Certifier

(Check only one)

30. Name and address of person who co

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2010 >

and manner stated.

mpleted cause of death (Item 23a) (Type, Print)

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 1:45 AM Jessie Μ. Young January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Rockville Montgomery If Under Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 924 1 XM 2 - F Months Days Hours Min Aug 28 85 Mississippi **Director** 399-24-1890 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 3310 North Leisure World Blvd, #215 20906 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates. 1943-46 White nd Mental Hygiene.
s marked other than "natura umatic event, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other thar amy injury or other traumatic event, the Monee. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Physicist US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Prentice Hiram Young Gillie Lilian McGehee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3310 North Leisure World Blvd #215 Silver Spring, Nancy Young/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/23/2010 Woodbine, Maryland Signature of Funeral Service Liceps Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 nomao 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ "Metastatic Cancer- unknown primary lung metastasis disease or condition resulting in death) , Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or ilinjury Due to for as a consequence of: for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year Unknown the detached 9 Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 🖾 Natural injury ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) ٥ J. Kou et chou, 063748 January 21, 2010 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855 31. Date filed (Month, Pay, 32. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney n 03285 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Marie Elinor Ashley 2. Date of Death 3. Time of Death February B, 2010 **Physician** 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Long View Nursing Home Manchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 1, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 XF Maryland 82 Director 214-24-0892 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County a or 28a-f show the notified at 1 ☐ Yes 2 No Maryland Director York Hanover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 17331 29 Arbor Lane be filed within 72 hours after death wintal Hygiene. dother than "natural", or items 23a eevent, the Medical Examiner must b r items 23a o Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2K No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Thomas Reiersen Marie Klecka is marked 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Arbor Lane Hanover, Pennsylvania 17331 Department of Health a Important: If item 27 is any Injury or other trac David L. Ashley - son 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Garrison Forest
Veterans Cemetery Feb. 17, 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Owings Mills, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Live ee 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 un Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Vascular Disease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last structure Pulmmary Discore Examiner burialphysician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perforn 2□ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 6 ☐Other (Specify) P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

be executed and Box 68760, P.O. Division or Vital Records, peen certificate has To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director After t completely filled in by the funera

Baltimore, Maryland 21215-0036

and 2 should be fi fealth and Mental F

the þ signed t After this

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2010

30. Name of address of person who completed cause of death (Item 23a) (Type, Print) 688 Poole Rd, Wistminster,

31. Date filed (Month, Day,

amend #9 Stere ANM Bha 63000 2/08/2016 Habith and Mental Hygiene amend #7 Per Ana BD G900 2/17/10 JH

Certificate of Death

Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 8°, 2010 6:00 AM M Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holland Manor Assisted Living Baltimore Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Chemmark **Funeral** 1 □ M 2 🗓 F (Month, Day, Yea, Months Days Hours Min 094-05-4479 Director 191 Maryland Usual Residence of Decedent ıral", or items 23a or 28a-f shov | Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore 1 Y Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Light Street #223 21230 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: "natural" 3 Widowed 4 Divorced if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education unk unk 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dagmar Bager Carl Jensen Nymann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13417 Blenfield Road Phoenix, MD William Collinge/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State and Andrew Myao Board 655 W. Baltimore Street 21. Signature of Funda Trice Scenswade rector Baltimore, MD 21201 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each light Immediate Cause (Final disease or condition resulting in death) monara ⊈πysician/ l Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner has been signed by the attending physician and je 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? page 2 should be detached for Day Month Year 1 ☐ Yes 2 ₹ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: ALF 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jel Redo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIGITAL ON LINTHICUM MO 705 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ February Ethel Winifred Alt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Atrium Village
5. Social Security Number Owings Mills 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 20, Countr Maryland Days Min. Hours 1 🗆 M 2 🖵 F 94 215-03-2275 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Completed by Funeral Director Maryland | Baltimore Owings Mills 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10910 Park Heights Avenue 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 K Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Librarian Enoch Pratt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Urban Bertha Reid Musser Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 Temple Cliff Rd., Pikesville, MD 21208 David N. Alt (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/8/10 4 Donation 5 Other (Specify) Baltimore Crematory Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Emor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dun to for as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day 1 Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ျင 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death

To the Funeral Director: A

completed filled in by the fi Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 7/2009

State Registrar 29b, Signature and tit

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3288 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 2010 3:30a M Louise Brown Catherine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Harford Upper Chesapeake Bel Air 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Davs Hours Count Maryland 213-32-9908 72. Aug. Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director 1 Yes 2 X No Aberdeen Harford Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a or ner must be r Funeral United States 21001 901 Barnett Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Examiner Armed Forces? Black, White, etc. or i þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Catherine Elliott Benjamin Meredith traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 4759 Bonnie Brae Road, Pikesville, Maryland 21208 Margaret Averno/ Sister item 2 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of February 5. ₽ 1 Burial 2 XCremation 3 Removal from State Department of Important: If any injury or once. Metro Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ENTEROCELITIS PIFFICILE CLOSTRIPIUM Physician/ disease or condition resulting in death) ↓ Medical Examiner MEUITUS, TXPE 'Z Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iiniury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Be the as IF FEMALE: use 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year ed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URINAPLY TRACT IN FECTION, PSELPCHONAT 1 Yes 2 No 3 Probably 4 Unknown SADAMOUS CELL CARCINOMA, LUNG 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope, performed r ARTERY PISEASE CORONARY 1 Yes 2 No Division of Vital 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 2 Vio ျ 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

State Registrar 31. Date filed (Month, Day, Year)

FEBRUARY 3, 2018

35 FULFORD AVE, IELAK 21014

w Nowalions

NOWAKOUSTER MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cecelia Boarman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-00666 State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1740 hrs January 22, 2010 Medical Examiner Cecilia Boarman 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Northwest Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Hours Director Country) Mary Land 217-38-7973 1 M 2 X F 69 DEC 3. 1940 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 X No Windsor Mill Baltimore hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 USA 7125 Fairbrook Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? White, etc. 1 Never Married 2 X No Yes 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: White 3 Widowed ≥ Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) ages 1 and 2 should be filed within 72 ho on of Health and Mental Hygiene. nt: If item 27 is marked other than "na other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Litton 12 Inspector 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Mary Boarman, John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ 1326 Germander Drive Belcamp, MD Ann F. Minsky, daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 02/09/10 Baltimore, MD Donation 5 Other Specify George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee 299 Frederick Road Baltimore, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Retween Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical X AMENDER 1,23a,27, X UNPENDED ME G900 2/17/10 TT per Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day 2 Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown the icate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. <u>a</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? 1 🗸 Yes 2 No ✓ Yes 2 26. Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be Hospital: 1 DOA Other Nursing Home 5 Residence 6 Other: 2 Proof ER/Outpatient 3 Inpatient 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: filled in by the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. COME January 23, 2010 30. Name and address of person who complete I cause of death (Ifem 23a) 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Assistant Medical Examiner

State Registrar 31. Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03290 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Jane Belt 2010 February 8:20 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Carroll Dove House Westminster 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days 1 M 2X F Months Hours Min. Country) Director 220-24-6535 Sept Marvland Usual Residence of Decedent 10b. County 10c. City. Town or Location be notified at 10a, State 10d. Inside City Limits Director 28a-f s 1 🗆 Yes 2 🔀 No Carroll Maryland Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 24 Timber Ridge Drive 21157 United States traumatic event, the Medical Examiner must or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 Never Married 2 Married within 72 hours after 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: "natural", Completed 3 KWidowed 4 Divorced White Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Warren W. Parrish Dorothy E. Crone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 448 Fuhrman Mill Road Hanover, Pennsylvania 17331 Edward W. Belt/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematdry 2/5/2010 Woodbine, Maryland re of Funeral Service Going Homes Cremation Service P.O. Box 784 - M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 nomao 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rates Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a nonsequence opcause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown signed by the a d be detached f 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Tyes 2 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 
Yes 2 
No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27, Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westmenster MD 21157

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3ay February 2010<sup>a</sup> 9:20 A M Neff Barnhart Julia Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carriage Hills Nursing Home Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 Months Days Hours Min. July 1, 1914 Country) Mississippi Director 545-18-7415 95 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 4514 Jamestown Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **Homemaker** Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William E. Neff Elizabeth Braswell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory E. Barnhart/son 115 Vallarta Court Solana Beach, California 92075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/8/2010 Woodbine, Maryland Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Thomas 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ STOMACH CANCER disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No ☐ Yes
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 ☐ Y eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital within 24 hours a

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao 10110 Molecular Drive, #206 Rockville, Maryland 20850 31. Date filed (Month, Day, Year) FEB 0 9 2010

200, MA

State Registrar 29b. Signature and title of certifier

0005 7124

29d. Date signed (Month. Dav. Year)

215110

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEB. 5, JOHN M. BANASHAK 2010 11:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death DUNDALK BALTIMORE GENESIS HERITAGE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV • 3, | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 € M 2 □ F 216-32-2531 74 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County EASTWOOD 1 ☐ Yes XXX No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7212 BRIDGEWOOD DRIVE 21224 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1↓JYes 2 □ No If Mes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced WHITE 1 □Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH College (1-4or 5+) UNION BRICKLAYER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery, crematory or other place ATLANTIC CREMATORY

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.

MARGARET

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7212 BRIDGEWOOD DRIVE, BALTIMORE, MARYLAND 21224

22. Name and Address of Facility CHARLES S. ZEILER & SON, INC.

Place Dindalk Mg 21222

Date 2/9/2010

6224 EASTERN AVE., BALTIMORE, MARYLAND

VAN HORN

20c. Location - City or Town, State

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 No

GLEN BURNIE, MARYLAND

21224

Year

4 Onknown

Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

Immediate Cause (Final disease or condition resulting in death)

1 - For State Registrar

10a, State

MD.

JOHN MICHAEL

23a. Part 1. Enter the disease shock, or heart failure.

19a. Informant's Name/Relationship (Type. Print)

20a. Method of Disposition
1 ☐ Burial 2 ★ Fremation 3 ☐ Removal from State

of Funeral Service License

HELEN BANASHAK/WIFE

4 □ Donation 5 □ Other (Specify)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show ms 23a or 28a-f sl

or items

Department of Health and Mential Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatte event, it all folial Examinationse.

Director

Funeral

<u>۾</u>

Completed

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examine burial-tran attending physician Physician/Medical as the use for cate has been signed by the page 2 should be detached <u>გ</u> Completed certificate ours after death.

eral Director: After this certificatilled in by the funeral director, I filled in by the funeral director, I Be Medical Certification: To

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an perform 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

To the Hospital within 24 hours a To the Funeral C completely IVa

State Registrar

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 03293 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY Day 4 ROSE BRAITMAN 2010 10:00 P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 1005 BROOKLANDWOOD ROAD LUTHERVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth **Funeral** Months Days Hours 1272171912 220-38-9028 97 Director Usual Residence of Decedent show or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 1005 BROOKLANDWOOD ROAD 21093 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: Armed Forces? Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Midowed 4 □ Divorced Specify: Completed WHITE traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) REGISTERED NURSE MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ WOLF RUBIN ANNA GOLACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health BARBARA BRAITMAN/DAUGHTER 1005 BROOKLANDWOOD ROAD, LUTHERVILLE, MD 21093 or other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot BALTO HEBREW BERRYMAN 2/8/2010 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Sepsis Priysician/ disease or condition resulting in death) Medical Due to ( r as a consequence of): days Examiner iration preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to lor as a consequence of ttending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death signed by the d 1 Yes 2 1 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No acci 24a. Was an autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this if illed in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D43936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas F. Lansda P. Tij M.D. 653 6535 N. Charles St. Baltimore MD Lansdale M.D. Thomas F.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BONDER e Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SEASONS HOSPICE AT NORTHWEST HOSP RANDALLSTOWN 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 8/18/11/920 ar) 125-09-0843 89 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director N/A 1 Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2500 W. BELVEDERE AVENUE, #310 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 Yes 2 No Specify: 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 Yes 2 If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE "natural", 3 X Widowed 4 □ Divorced Year or Dates it of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical or 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) POSTAL CARRIER US POST OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BARAN GUSSIE WILLIAM BENDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 FARRINGDON ROAD, BALTIMORE, MD SHEILA ORSHAN/DAUGHTER permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition
1 D Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State NEW MONTEFIORE CEM. 2/7/2010 PINELAWN, NY 4 Donation 5 Other (Specify) ature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one can Immediate Cause (Final Onset and Death Priysician/ cinom 6 AS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 28a. Date of injury (Month, Day 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work' 5 Pending 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 119G Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

(Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOR

9

Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month. Day. Year)

2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Albert G. Beard 11:22p 31 January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carrol1 Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** 1√ M 2□ F Months Days Hours 214-28-1809 Director May 11 1929 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at MD Carrol1 1 ☐ Yes 2 ☐ No Funeral Director Svkesville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5629 Bartholow Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manufacturing machinest 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Beard Elizabeth Madden ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Vivian Beard (spouse) 5629 Bartholow Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of I Important: If Ite any Injury or o once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Hought Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hoone /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 2 □No 1 Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes COF 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? Chronic certificate olace 2 NO 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Folde 130119 2-3-2010

ų v

State

Registrar

DHMH 17 Rev 1/2001

Sykesville

2178

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 09

KELVILLE

32. legistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:13 a<sup>M</sup> February 6, 2010 Erma Baublitz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Sykesville Fairhaven Nursine Home If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Yrs. 95 Aug 4, Director 212-34-7747 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or them on the trainment. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 XNo Directo Baltimore Owings Mills MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21117 12127 Park Heights Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐Yes 2 🖾 No Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 3e Amelia Clusman Underwood ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20817 Bethesda, MD Deborah O'Neill 9116 Town Gate Lane Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Park 2/20/10 Finksburg, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee Eline Funeral Home Reisterstown, MD DUN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and/Death Immediate Cause (Final nultis stem Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obstra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 I Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ecenoratino 24a. Was an has e 2 autopsy performed' certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 4 Homicide

or Attending Physician: The law requires that the death certificate be executed eral Director: After this filled in by the funeral dir within 24 hours a To the Funeral D the Hospital

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

29b. Signature and title of centifie

31. Date filed (Month, Day, Year)

29a. Certifier

one)

ical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1645 Mam lan MD

32. Redistrar's Signature

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	d / Department of Health  Certificate of Death		eg. No.
	Physicia	20	1. Decedent's Name (First, Middle, tast)		2. Date of Death	
	/Medic	al .	4a. Facility Name (If not institution, give street and number)/	4a. City, Town, or Location	of Death	4c. County of Death
age of	Examin	er	Northwest Hospital	(Kondall)	Hown MID	Baltimore
	Funeral Director		5. Social Security Number   6. Sex	Ast birthday)  Yrs.  If Under 1 Year   If Under	8. Date of Birth (Month, Day, Dec. 18,	Year) 9. Birthplace (State or Foreign Country) Maryland
	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location		10d. Inside City Limits
	e Mar Ba-f sk	Director	MD Baltimore	Reisterstown		1 ☐ Yes 2 <b>X</b> ☐ No
	a or 2	Ö	10e. Street and Number 111 Sacred Heart Lane	10f. Zip Code 21136	1	0g. Citizen of What Country? U.S.A.
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?		rigin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene.  so other than "natural", or items 23a or 28a-f show event, it a Modical Examination must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □Yes 2√√No Specify		Specify: White
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	st of working	16b. Kind of Business/Industry
212	i within giene.	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 12	Manager_		C & P Telephone Co.
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ryla	2 should be and Menta Is marked aumatic ev	ဥ	Unknown Martin  19a. Informant's Name/Relationship (Type. Print)	Ann 19b. Mailing Address (Street and Numb		
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		Leo A. Briner, II Son	111 Sacred Heart		•
Baltimore,				lace of Disposition (Name of emetery, crematory or other place)		20c. Location - City or Town, State
ij	t. Pages rtment of rtant: If it		4 □ Donation 5 □ Other (Specify) Lak	te View Mem. Park		Sykesville, MD
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee M Fent	22. Name and Address of Facil	HOME Reist	sterstown Road erstown, MD 21136
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	n. Do not enter the mode of dying, such a	s cardiac or respiratory arm	est, Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)  Due to (or as / consequ	uence of		
1	Examiner		1 4 Mos	Most Hypertens	m	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	uence of)		
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68760,	tificate be executed g physician and as the burial-transit	edical	d			
			IF FEMALE: 23c. If yes, outcome of pregna	incy		23d. Date of delivery
O. Box	The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	I death 3 Ectopic pregnancy		Month Day Year
S, G,	res that igned b	by Ph	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part	1. 23e. Did to	bacco use contribute to the cause of death?
ord	w require been si should t					es 2 No 3 Probably 4 Unknown
Vital Records,	The law sate has t page 2 sl	Completed			24a. Was a autops perform	prior to completion of cause of death?
ital		Be C	25. Was case referre medical examiner?		1 □Yes ce of Death <i>(Check only on</i>	
of V	S S	မ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐	ER/Outpatient 3 DOA Other: 4 N 28b. Time of 28c. Injury at		ence 6 ☐ Other (Specify) ow injury occurred
O	Attending r death. sctor: After by the funer	tion	27. Man or of Death  1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day, Year)	Injury  M  1   Yes  200. Injury at Work?  M  1   Yes  2		ow rijury occurred
Division	i Pire	Certification:	a Could not be	ome, farm, street, factory, office	28f. Location (S. City or Town	treet and Number or Rural Route Number, n, State)
	e Hospital 24 hours a Funeral letely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death occurred at the time, date a tion and/or investigation, in my opinion, de	and place, and due to the ceath occurred at the time, c	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the Comple	Me	296 Signature and title of certifier	29c. License number	2	29d. Date signed (Month, Day, Year)
			A Some w	1246314	4	2/0/2010
			30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	YRd Ron	Mallstown MD
Н	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture A barrel		

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ar If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 10/27/1919 9. Birthplace Country) 7. Age (In yrs. last birthday (State or Foreign **Funeral** 1 ☐ M 2 💢 F 90 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5806 GREENSPRING AVENUE Funeral 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite Iny or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ 3 X Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISRAEL UNKNOWN STEELE 2 JENNIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DIANE LEVINE / DAUGHTER 5806 GREENSPRING AVENUE, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 3 Removal from State 1 ☐ Burial 2 ☐ Cremation permit. Page Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) SHAARE TORAH CEMETERY 2/5/10 CARRICK, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any second to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1∐ Yes 2 or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: P 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 3 D CRN 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Copper Ridge, 710 Obrecht Rd, Sykoville, Maryland

4,2010

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State o	f Marylan		artment rtificate				1ental Hy	•	001		00000
			Registrar  1. Decedent's Name (First	st, Middle, La	st)			incare	, 0, 1	- Catiri		2. Date of De	Reg. No	201		3. Time of Death
	Physici		Rowena		g-Lan	Chu						Month Februa	Da	y 201	Year	10:20 A <sup>M</sup>
Way.	/Medic Examin		4a. Facility Name (If not i					4b. City, T	own, or	Location	of Death	rebrua		. County o		10:20 A
di	Exami	•	Rockville	Nursi	na Home			Roc	ckvi	116				Mor	ntgo	nerv
	Funeral		5. Social Security Number	r 6. S	ex	7. Age (In yrs.	last birthday)	If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth			place (State or Foreign
	Director		324-32-6286		□M 2 <b>X</b> F	73	Yrs.	IVIORITIS	Days	Hours	IVIII.	July 3	, 19	36	Cour	""China
	pur *		Usual Residence of Dece 10a. State 10b.	County		10c Cit	y, Town or Lo	cation							T 4	0d. Inside City Limits
	sho	5		1		100. 01									1	1 ☐ Yes 2 ☐ No
	28a-1	ect	Maryland M	ontgom	ery		Ro	ckvill 10f. Zip (				1	10- 0	itizen of W	hat Caus	
	with a or	Funeral Director		T				Tol. Zip (								
	ns 23	era	6936 Wick	Lane	12. Was Dece	edent Ever in U.	S. 13.1	Was Decede	208		igin? (Sp	ecify Yes or N		ited		CES can Indian,
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examinar must be notified at		1 Never Married 2	2 Married	Armed Fo 1 ☐ Yes	rces? 2X No		If Yes, specif	fy Cuba	n, Mexica	n, Puerto	Rican, etc.)			, White,	
03	rai", o	b	3 ☐ Widowed 4 ☐ [	Divorced	If Yes, Giv Year or D			1∐Yes 2	□ <b>X</b> No	Specify.	:			Specify:	As	ian
21215-0036	n 72 hours "natural"; udical Exe	Completed	15. [ (Specify on	Decedent's Ed	lucation ide completed)		16a. Dece	dent's Usual kind of work	Occupa	ation	st of work	ina	16b. k	Kind of Bus	siness/In	dustry
121		m m	Elementary/Secondary		College (1	-4or 5+)	life.	DO NOT use	retired	)		9				
2.	Hygie Hygie Hert	ပိ	17. Father's Name (First,	Middle Leet	5+			Chen	nist		- d- 11	/First Adiabati			odak	
anc	12 should be filed within " h and Mental Hygiene. 7 is marked other than " traumetic event, the Med	Be	TY Wu	Middle, Last)						18. MOTH		First, Middle Chiang		п Бигпате	*)	
Ž	hould d Me mark metic	2	19a. Informant's Name/F	Polationahin /	Time Orint)		405 14-35-		(04			al Route Numi		T	24-4- 7:	
Maryland			Allan Y C				1							,		, NJ 08836
a)	s t and 2 f Health a ftem 27 is other trat		20a. Method of Disposition			20b. F	Place of Dispo	sition (Name	e of	- 1		Date		ocation - (		
οn	ent of ent of ht: If i		1 ☐ Buria! 2 <b>X</b> Cre 4 ☐ Donation 5 ☐			State C	emetery, crer al Jou	natory or oth	ner plac		, 2/0	/2010			•	
Baltimore,	permit. Pages 1 and Department of Heali Importent: If item 2 eny Injury or other once.		21. Signature of Funeral		··	1. 711									<u> </u>	Maryland
B	Depa Impo eny Ir		nuanit	-	dans	_ M009	57   B	oing F everl	iome 7 Tu	Hecl	natio	n Serv	ice Cl	P.O.	BOX 7111	/84 e, MD 21029
			23a. Part 1. Enter the dis	ease, or com	plications that c	aused the deat	-							.CLT.ID		Approximate
	Physician		shock, or heart faild Immediate Cause (Final	ure. List only												Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		u	ric Can									-	
	Examiner			- 1	ь											
V	D .±	iner	Sequentially list condition if any, leading to immedia cause. Enter Underlying	ate	Due to (	or as a conseq	uence of):									
1	cate be executed physician end the burial-transit	Examiner	Cause (Disease or Irijury that initiated events resulting in death) Last		C											
90	be ex cian e	<u> </u>	resulting in death) Last		Due to (	or as a conseq	uence of):									
68760,	icate be physicial the buri	dical			d											
			IF FEMALE:		22c If yes out	nome of progra	2004	1111								
Вох	atten for us	Physiclan/M	23b. Was decedent preg in the past 12 month		1 Live I	come of pregna pirth 2 Peta	Ideath 3	Ectopic pre		/				23d. Date Mor		ery Day Year
Ö	the dr	ysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown		9 ☐ Unkn	nant at time of o own	eatri 5	Other (spe	еспу)		-					
σ.	law requires thet the death certi as been signed by the attending 2 should be detached for use a:	Ph.	Part II. Other significant	conditions	ontributing to de	eath but not res	ulting in the u	nderlying car	use give	en in Part I	l.	23e. Did	tobacco	use contri	ibute to t	he cause of death?
of Vital Records,	luires n sign ld be	d by										1 🗆	Yes 2	2 □ No	3 ☐ Prol	bably 4 🔀 Unknown
õ	law requii as been s 2 should	Completed			_							24a, Was	an an	24h W	lere auto	ppsy findings available
Re	The lav ate has page 2:	E C										auto perf	opsy ormed?	l d	rior to co eath?	mpletion of cause of
ta	i <b>clen:</b> Th certificate ector, pag	BeC	25. Was case referred to	medical						26 Place	o of Dogs	1 ☐ Yes h (Check only		0 1	∐Yes	2 □ No
>	Physiclen: r this certific ral director, I		examiner? 1 ☐ Yes 2 ☐ <b>X</b> No		Hospital:	npatient 2 🗆	ER/Outpatier	nt 3 🗆 DOA	Othe	)r*		me 5 ☐ Res		6 🗀 Othe	r (Snoci	6.1
0	ding Physicien: The n. After this certificate h funeral director, page	Certification: To	27. Manner of Death		28a. Date		28b. Time of		Bc. Injury Work	/ at		28d. Describe				
<u>.</u>	Attending r death. ector: After y the fune	atic	2 🗖 Accident	Pending investigation	1	in, Day, rear)	injury	М		r Yes 2□	No					
Division	r Atte	titie	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - At ho	ome, farm, str	eet, factory,	office			28f. Location City or To	(Street a	ind Numbe	er or Run	al Route Number,
	ital c urs af rel Di															
	Hosp 4 hot Fune ely fil		(Check only 2	Certifying Ph Medical Exar	ysician: To the niner: On the b	asis of examina	wledge, deat	h occurred a	at the tin	ne, date a	nd place, ath occur	and due to th	e cause(	s) and ma	nner as	stated. o the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	ONE		and man	ner stated.					33001					
	vit co	-	29b. Signature and title of	certifier		11		29c.		number						Day, Year)
				0					D0	06462	24			Febru	ary	5, 2010
			30. Name and address of													
	Sta	to	Sandeep Sl 31. Date filed (Month, Da	v. Year)	1VI . I /4	13 Summe egistrar's <b>#</b> gna	er Wall	C Driv	e G	aithe	ersbu	rg, Ma	ryla	nd 20	878	
	Sta	rc	EERA	1 JULY	M	A A	Mark									

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of M	laryland / Dep			nd Mental Hy	giene		
		Registrar  1. Decedent's Name (First, Midd	dle last)	Ce	rtificate of I	Death	100, 10	Reg. No.	010	103300
Physic			rcoran, Jr.				2. Date of De Month 02/02/		Year	3. Time of Death
Med Exam		4a. Facility Name (if not institution			4b. City, Town, o	or Location of I			unty of Death	10.10 A
.)		159 Sandy Hill	l Drive		Ocean Ci	ity			cester	
Funera		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24		rth		place (State or Foreign
Directo		214-26-0125 Usual Residence of Decedent		79 Yrs.			Mar. 6,	1930 1930	Penn	sylvania
and show	ō	10a. State 10b. Coun	ity	10c. City, Town or Lo	ocation				1	10d. Inside City Limits
Maryl 28a-f otified	rect	MD Worce	ester	Ocean Ci	ty					1 Yes 2 □ No
h the a or 2 be no	a D	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
th wit ms 23 must	Funeral Director	159 Sandy Hill			21842			USA		
or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☎ M	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		Race - Americ Black, White,	
ours afte	od be	3 Widowed 4 Divorce	15 Tan Cive	INO	1 ☐ Yes 2 🙀 No	Specify:		Spe	cify: Wh	ite
2 hou "natu dical	Completed	15. Deced	dent's Education phest grade completed)	16a. Dece	dent's Usual Occup	oation	fworking	16b. Kind o	of Business In	
than	l e	Elementary/Seconday (0-12)		5+) life. L	OO NOT use retired)		i working	M = 1	1 04	
Hygie	Be	12 17. Father's Name (First, Middle	a Last)	Fores	st Ranger	T	- Name (First Address		and St	ate
be fill ental ked c	2	John Joseph Co					s Name <i>(First, Middle,</i> beth Cecel		,	
ary and M s mar		19a. Informant's Name/Relation		19b. Maili	na Address (Street	and Number o	or Rural Route Numbe	er. City or Tow	n. State Zin (	Code)
od 2 sl salth a n 27 is		Grace Corco	oran (wife)	- 1			e Ocean	-		•
of He		20a. Method of Disposition	on 3 🗆 Removal from State	20b. Place of Dispo			Date		on - City or To	
Pag ment tant:		4 Donation 5 Other		·		· · ·	ев. 5, 2010	Glen :	Burnie	, Maryland
partitions, Maryjaniu Z1Z13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		21. Sign ture of reperal Service	e Licensee	2	2. Name and Addre Kirkley- 4.21 Crai	ss of Facility Ruddic	k Funeral SE; Gler	Home,	P.A.	21061
		23a. Part 1. Enter the disease,	or complications that caused tonly one cause on each lin	d the death. Do not ent	er the mode of dyir	ng, such as ca	rdiac or respiratory ar	rrest,	, in	Approximate
Physician		Immediate Cause (Final disease or condition	tonly one cause on each lin	C	Δ.	1.	4		- 1	Interval Between Onset and Death
Medica Examine		resulting in death)	Due to (or as	a conseq ence of):	/ CAPE	romy	palny			la yrr
Lamine		Sequentially list conditions,	b	Atherosel	notic	Cordio	vascular	as.		20 405
sit 3d	n ji	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a consequence of).						
xecute and	Exal	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):			·			
rate be executed physician and the burial-transit	dical Examiner		L <sub>d</sub>							
ficate g phy as the	Ι Ψ	IF FEMALE:	- 0.							
attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregnancy 2 Fetal death 3	Ectopic pregnanc	CV		23d.	Date of delive	ery
requires that the deat been signed by the at should be detached fo	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown		Other (specify)				Month	Day Year
that the the period be deta	by P	Part II. Other significant condi	/ /		underlying cause gi	ven in Part I.	23e. Did t	obacco use c	ontribute to th	ne cause of death?
quires quires en sig	led	Type II	Prabetes M	rellities			1 🔯	Yes 2 N	o 3 🗆 Prot	bably 4 🗆 Unknown
law relay be	Completed						24a. Was auto	an 24	b. Were autop	psy findings available mpletion of cause of
The la	S						perfo	ormed?	death?	
Physician; The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				(Check only one)			
Phys this	은	1 L Yes 2 No	1  Inpati	ient 2 ER/Outpatie		4 L Nursi	ing Home 5 K Resi			)
ath. : After	Certificate:	1 Natural 5 Pend		y, Year) injury	work	yaı <br Yes 2. □Ne	28d. Describe t	now injury occ	curred	
Atter er dea ector by the	ığı,	3 Suicide 6 Coul	ld not be 28e. Place of Injuried	ury - At home, farm, str			28f. Location (		mber or Rural	Route Number,
ital or urs after all Direction		L	building, et	c. (Specify)			City or Tov			
To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending I completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 ☐ Medical	ng Physician: To the best of I Examiner: On the basis of e ng Nurse Practioner: To the	examination and/or inves	tigation, in my opinic	on, death occu	rred at the time, date a	and place, and	due to the car	use(s) and manner stated
To the vithing to the complex	-	29b. Signature and title of certifi		,	29c. Licens				ned (Month, I	
		1		0		DZY9	86	12.	2/10	
16		30. Name and address of person  Robert J. Roll	n who completed cause of d	death (Item 23a) (Type, I	Print)  Dr. Bl	61 C.1	Church	md 2	1801	
St Regist	ate rar	30. Name and address of person  Robert J. Reil  31. Date filed (Month, Day Year)	0 9 20 10 <sup>32. Registra</sup>	ar's Signature	ball	3.0		G.		
					-					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Katherine Curtis January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BALTIMORE AGNE If Under 1 Year | If Under 24 Hrs. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F Months Days Hours unk Director 73 Apr 26, 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It we die a Frami in it is a to a refilted. 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502 Frederick Road 21228 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian, 1 Never Married 2 Married 1 □Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 📉 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 21. Signature Funeral School Signature Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DECUBITUS ULCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sella consequence of) the attending physician and hed for use as the burial-transit DEMENTIA Due to (or as a consequence of): 68760. Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a P.O. I 1 ☐ Yes 2 ☐ No 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 No 1 ☐ Yes 3 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 3 No □ Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P-24064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton Baltimore Auenue 31. Date filed (Month, Day, Year) 32. Registrar's Sanatur State FEB 0 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10:35 p M J. Coop Edward February 7, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Futurecare Cherrywood Reisterstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2 ☐ F Yrs. Aug 8, 1916 Maryland Director 217-01-9161 93 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r items 23s or 28s-f show 1 ☐ Yes 2 🔀 No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 943 Shirley Manor Road 21136 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "naturel", or items 23s emplightry or other traumatic avent. It a Medical Exert it was final and. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) W.T. Cowan Trucking 10 Chauffeur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Elizabeth Frederick Joseph Coop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 943 Shirley Manor Road Reisterstown, MD 21136 Edna J. Coop 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Pk Sykesville, MD unk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Po not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physician and debacked for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown been signated Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has l certificate 2 No 1 TYes 25. Was case referred to medical Be 26. Place of Death | Check only one Hospitaf: 1 ☐ Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 N6 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) vithin 2 29b. Signature and title of certifier of death (Item 23a) (Type, Print) ay, Year) 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c \$30 per DVR g900 2/9/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 30, 2010 8:45 P, M Bertha May DeVese /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Homewood At Crumland Farms If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Nov 17, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🖫 F Yrs. 1913 96 Director 214-01-6165 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Frederick Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7407 Willow Road 21704 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify Specify: white Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) of Health and Mental Hygiene. 0 factory worker distillery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Joseph DeVese Rosa Lockman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 20723 Susan Brooks/Graelock Road Laurel, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Servic Licensee Ronald S. Wate Baltimore, MD 21
Do not enter the mode of dying, such as car 21201 23a. Part 1. Enter the disease, or complications that caused the leath. shock, or heart failure. List only one cause on each ine. Immediate C use (Final disease or condition resulting in deat ) **Physician** /Medical nsequence of): Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a co Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a Ö 9□Unknown 9 Unknown Part II. Other significant coorditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 → No 3 □ Probably 4 □ Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an inclus + c phy! Cians autopsy performed? certificate ! 2 No 1 ☐ Yes 1□ Yes 2 🖽 6 Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 1 🗌 Inpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🕰 ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D16428 cause of death (Item 23a) (Type, Print) 30. Name and address of person ho completed 300 W. Ninth Street Frederick, MD 21701 Ε. Cline, MDCasper 2. Registrar's Signature State Registrar

Bertha Deves

OSS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician January 29 Barbara Dorsey 2010 10:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 413 Hideway Loop; Apt A Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔽 F unk 57 Director Nov 16, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Inc. Medical Experient must be realthed at 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 413 Hideway Loop #A 21061 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: unk 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: black 2 3 Widowed 4 Divorced Completed unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. Informant's Name/Relationship (Type. Print) Seasons Hospice 6934 Aviation Blvd. Ste.N Glen Burnie,MD 20161 20c. Location - City or Town, State 20a. Method of Disposition Department of H
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any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature of Eune al Survice Licensee ROTH I 2 State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Causa (Final Physician VETASTATIC LOWRECAM disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if u.y. leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or eas a nonsequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: , 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral E

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00066507 2000 HYSICIAN UNIVERSITY

Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2.09.2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical Endocarditis disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and bunial-transit Cause (Disease of lingury that initiated events resulting in death) Last 07 FEBIO Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical death certificate be 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death signed by the aid be detached for 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ IV Drug Use AARON 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed plnous has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page, Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No 2 🔀 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 🗆 No မှ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation M 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D66066 of death (Item 23a) (Type, Print) \$600 and Georgeten ld, Betterday up MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

4a. Facility Name (If not institution, give street and number)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

**Examiner** 

**Funeral** Director

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	OHRC					Oa	Kla	nd				xarre	++	
	5. Social Security Number 218–30–7000	6. Sex	M 2□F	7. Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	If Under Months	r 1 Year	Hours	Min.	Date of Birth (Month, Day	, Year)	(	irthplace (State or I Country)	Foreign
	Usual Residence of Decedent			74					A	pr 17,	193	35 Mai	ryland	
ľ	10a. State 10b. Cou			10c. City	, Town or Loc	cation							10d. Inside City	Limits
ctor	MD Garro	ett			0akla	and			<u></u>				1 □Yes 2	X No
	10e. Street and Number 706 Alder St:	root				10f. Zip		.550		1		izen of What ( USA	Country?	
era			12 Was Door	dent Ever in U.S	C 12 V	Van Dono			nin? /Specif	y Yes or No-			nerican Indian,	
Š	11. Marital Status 1 □ Never Married 2 ☒ N		Armed Fo 1 ☐ Yes	rces?	3. 13. V	Yes, spe	ecify Cuban,	Mexicar	, Puerto Ric	can, etc.)		Black, Wh		
Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divore		If Yes, Giv Year or Da	e -	1	☐ Yes	2 <b>∏</b> No	Specify:		- 2		Specify: W		
etec	15. Dece (Specify only hig	dent's Educ ghest grade	cation completed)		16a. Deced	ent's Usu kind of wo	ial Occupati ork done dui ise retired)	on ring mosi	of working	unk	16b. Ki	ind of Busines	ss/Industry	
duc	Elementary/Secondary (0-1:	2)	College (1	-4or 5+)	life. L	OO NOT u	ise retired)				ma	intena	nce	
Ö	17. Father's Name (First, Midd	dle, Last)					1	8. Mothe	r's Name (F	irst, Middle,	Maiden	Surname)		******
To Be	Richard Jo	seph	Elder	Sr				Не	elen M	farie S	Shaf	fer		
•	19a. Informant's Name/Relation	onship (Typ	oe. Print)		19b. Mailin	g Address	s (Street an	d Numbe			r, City o	or Town, State	, Zip Code)	
	Donna Leeger	spou:	se	Jack D			)aklan	id, M	D 21	550	00- 1-	antine Oite	as Taura Otata	
	20a. Method of Disposition  1 ☐ Burial 2 ☐ Crematic  4 ☒ Donation 5 ☐ Othe		emoval from	1 0	lace of Disposemetery, cren	natory or o	other place)		Date		200. L0	cation - City	or Town, State	
	21. Signatur Funeral Service Rona La	io Licen		rector	_		nd Address Anaton ore, 1	-		655 W.	Ba1	timore	Street	
	23a. Part1. Enter the disease shock, or heart failure.	, or compli	cations that c	aused the death	. Do not ente	er the mod	de of dying,	such as	cardiac or r	espiratory arr	rest,		Approximate Interval Between	een
	Immediate Cause (Final disease or condition	List only of	ie cause on e	Danel	1.66	0.0	4:1	01	25000	Duch	L-61.1.	of Rati	Onset and De	ath
	resulting in death)	a	Due to (	or as a consequ	tence of):	even	rivel	el a	4000	1 624 60		ej Rais	and C	very
	Sequentially list conditions	, b												
lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to (	or as a consequ	uence of):									
хап	that initiated events resulting in death) Last	٥	Due to (	or as a consequ	uence of):									
by Physician/Medical Examlner		L.	l											
Med	IF FEMALE:													
an/l	23b. Was decedent pregnant in the past 12 months?	2	1☐Live b	come pf pregna pirth 2 ☐ Fetal	Ideath 3□	Ectopic p	pregnancy					23d. Date of o Month	delivery Day Ye	ar
/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregn 9□Unkno	ant at time of de own	eath 5□	Other (s	pecify)					Month	Duy 10	
P.	Part II. Other significant cond	ditions cor	ntributina to de	eath but not resu	ulting in the ur	nderlyina (	cause given	in Part I		23e. Did to	bacco u	use contribute	to the cause of de	ath?
	, and a series engineering			AD		,	g						Probably 4 ☐Ur	
etec			الـ ا	20										
Be Completed				121							sy med?	prior t death		ise of
ပ္	25. Was case referred to med	lical						26 Place	of Death //	1□ Yes Check only or	2 No	1□Y	es 2 No	
To B	examiner? 1 ☐ Yes 2☐ No		lospital:	npatient 2	ER/Outpatien	t 3 🗆 D0	Othor		_			6 □Other (S	necify)	
ı.T	27. Manner of Death	2270	28a. Date	<del></del>	28b. Time of Injury		28c. Injury a Work?			d. Describe h			p cony,	
atio	Z LI Accident	estigation	(1110111	in, Day rear)	ngary	М		es 2 🗆	No					
Tific		uld not be ermined	28e. Place buildi	of injury - At ho ng, etc. (Specify	me, farm, str	et, factor	ry, office		28f	f. Location (S City or Tow			Rural Route Numb	er,
S	29a, Certifier 1 Certi	fylna Phys	ician: To the	best of my know	wledge death	OCCURREN	d at the time	. date an	nd place, an	d due to the	cause/s	) and manner	as stated	
Medical Certification:			ner: On the b			vestigation	n, in my opi	nion, dea		at the time,	date an	d place, and o	due to the cause(s)	
Σ	29b. Signature and title of cer	tifier	(1)			29	c. License		9 **	1			onth, Day, Year)	
		ナー	10km	nn			וט	13	55		21	11201	U	
	30. Name and address of pers		1				1 0 5	i	^	1 . 1	1 .			
	Thomas Johnson Jan Ye	1050		311 N egistrar's Signa	orth F	ourt	th St	reet	00	eklan	9 1	ALD S	21550	
7.5	LUIT DAID HIDU HWUHKII, DAY, 16	1411	LAUD. I	omoriai o diglia										

4b. City, Town, or Location of Death

03307

3. Time of Death

9:25 PMM

Reg. No.

Year

4c. County of Death

2010

State Registrar

# Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760,

	For State		State of N	/larylan		rtment of F <i>tificate of I</i>	lealth and N						
_	1. Decedent's Name (i	First, Middle, Lasi								2. Date of Death 3. Time			
ician			, Parnham 1	Eichin	iger			Februa	rv Day	, 2010		М	
dical niner	4a. Facility Name (If no					4b. City, Town, or	Location of Death			County of Death			
	1800 Fall	lstaff C	ourt			]	Eldersbur	g		Carr	o11		
al	5. Social Security Num	4.0		Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Co	nplace (State or Fore	gn	
or	019-30-812		□M 2√□ F	71	Yrs.			July 2	5, 1	938	MA		
	Usual Residence of De 10a. State 1	Ob. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limi	ts	
once.  To Be Completed by Funeral Director	MD	Carro	11		F	ldersburg	•				1 □Yes 2 □N	ю	
Directo	10e. Street and Number		T_T			10f. Zip Code	8		10g. Citiz	zen of What Co	untry?	_	
a D	1800 Fall	lstaff C	ourt			2:	1784			U	SA		
Funeral	11. Marital Status		12. Was Deceder Armed Forces	t Ever in U.	S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	)- 1	14. Race - Amer Black, White			
기	1 Never Married		1 ☐Yes 2 ☐ If Yes, Give			Yes 2√2 No	Specify:	, , ,					
d by	3 X Widowed 4 [		Year or Dates	:		Λ				W11	ite		
Completed	(Specify	5. Decedent's Edu only highest grad	le completed)		(Give	ient's Usual Occup kind of work done of OO NOT use retired	during most of work d)	ring	IOD. KII	nd of Business/I	ndustry		
E O	Elementary/Seconda	ary (0-12)	College (1-4o	r 5+)		egistere				Health	Care		
Be C	17. Father's Name (Fin	rst, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden S		-		
10 E	Ear1	l Parnha	n				Esth	er Mass	ey				
ľ	19a. Informant's Name	e/Relationship (7)	ype. Print)		19b. Mailin	g Address (Street	and Number or Rui	ral Route Numb	er, City or	Town, State, Z	(ip Code)		
	Robin Minr	nick (Dan	ughter)				ge Drive,						
	20a. Method of Dispos		Removal from Stat			sition (Name of natory or other plac		Date		cation - City or			
	4☐Donation 5	Other (Specify,	)	Arl		National	1	7/2010		lington	, VA		
	21. Signature of Fune	eral Service Licens	Llas L. let	- Mo	HA DO	I CHT FUNI	ss of Facility ERAL HOME Sykesvil	& CHAP	EL,	P.A.			
	23a. Part 1. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death)	failure. List only o	ne cause on each	ed the death	n. Do not ent						Approximate Interval Between Onset and Death		
al Examiner	Sequentially list condi- if am leadin to imme- cause. Enter Underlyl Cause (Disease or inji- that initiated events resulting in death) Las	ing ury	c. Dyslig	as a consequence	mia								
hysician/Medical	IF FEMALE: 23b. Was decedent printhe past 12 m 1 □ Yes 2 M/N 9 □ Unknown	onths?	d	2 ☐ Feta tat time of c	death 3	Ectopic pregnanc Other (specify)	ry		2	23d. Date of del Month	ivery Day Year		
by P	Part II. Other significa	ant conditions co	ntributing to death	but not rest	ulting in the ur	nderlying cause giv	en in Part I.		tobacco us		the cause of death?	wn.	
pleted								24a. Was	an	24b. Were au	topsy findings availat	ole	
Compl								perfo	rmed? 2 No	death? 1 ☐ Yes	_		
Be (	25. Was case referred examiner?	· ⊢					26. Place of Deat	th (Check only)	one)			_	
2	1 ☐ Yes / 2 🔽 No	)			ER/Outpatien		4 □ Nursing H			i □Other (Spe	cify)		
Certification:	2 Accident	5 ☐ Pending investigation 6 ☐ Could not be		Day, Year)	28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe			ural Dayte Monte		
	4 Homicide	determined	building,	etc. (Specif	y) 	•		City or To	wn, State)			State or Foreign  State or Foreign  Side City Limits  Side City Limits  Yes 2 No  dian,  Yes 2 No  Year  Year  Year  Year  Year  Year  Year  Year  A Unknown  Indings available fon of cause of No  The Number,  Cause(s)	
Medical	(Check only 2[ one)	☐ Medical Exam		of examina		vestigation, in my o	me, date and place opinion, death occu		date and	place, and due	to the cause(s)	_	
~	29b. Signature and till	e officertifier an	h.D	,		D/63			3 Date	e signed (Monti			
	30. Name and address Elizabeth 31. Date filed (Month,					*	ersburg,	MD 2178	84	1			
tate trar	31. Date filed (Month,	FEB 09	2010 2. 192	were signa	A. 1	parks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 7:00 PM GCZA 2010 J. 03 FEHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Baynew Conter 8. Date of Birth (Month, Day, Year) Baltimore ear | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F PA 79 4-8-1930 213-26-7324 Director Usual Residence of Decedent 10d, Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examination rust by notified at 1 Tyes 2 □ No Baltimore Dundalk Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1908 Adams Road 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tyes 2 No
If Yes, Give
Year or Dates: WWII Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) es 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Geza Frank Feher Anna Irene Feher ၉ 19a. Informant's Name/Relationship (Type. Print)
Sister-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State <u>Laverne Simmons</u> Baltimore. 20a, Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages Department o Important: If any injury or once. 9 Bayview Crematory 2-5-10 Baltimore,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronic obstructive Pulmonary disease **Physician** stage disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the burit IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Ö 1 □Yes 2 □ No a □ I Inknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, \$ Parkinsons 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Demon Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

2020

State Registrar

DHMH 17 Rev 1/2001

FEB 0 0 2010

29b. Signature and title of certifier

Jigous hah 31 Date filed (Month, Day, Year) MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8813

29c. License number

D69540

Rel suite 204 Parkville MD

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State of	Maryland		artment of H		Mental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of Dea	Reg. No.	10,23310	
	Physicia	n/						Month	Day	Year	
	Medic Examin		Betty C. Forden  4a. Facility Name (if not institution, give street and number	r)		4b. City, Town, or I	ocation of Death	Februar	201 4c. County of		
1	LXaIIIII	CI	Casey House				kville			tgomery	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. la:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	f Birth 9. Birthplace (State or Foreign		
	Director		037–12–0435 1 □ M 2X F	88	Yrs.	Months Days	Hours Will.	June 7	, 'f 921	Maryland Maryland	
	od at	_	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	arylar a-f st fied a	ecto	Maryland Montgomery		,	Takoma Pa	ark			1  ✓ Yes 2 □ No	
	or 28	Ē	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?	
	with t	Funeral Director	7402 Glenside Drive			20912			Unit	ted States	
	tems rems	ᇤ	11. Marital Status 12. Was Decede Armed Force			Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No-	14. Race	- American Indian,	
36	", or	þ	1 Never Married 2 Married 1 Yes 2			Yes 2 No	Specify:	Thousand Story	Specify:	K, White, etc.	
215-0036	ours a atural	Completed	3   Widowed 4 □ Divorced Year or Date  15. Decedent's Education	i.		lent's Usual Occupa	tion		1 '	White	
15	72 h an "na Media	윤	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4		(Give I	kind of work done du O NOT use retired)	iring most of work	king	16b. Kind of Bu	siness industry	
212	withir giene er tha		Elementary/Seconday (0-12) College (1-4	я 5+)	Te	acher				Education	
р	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene.  Item 27 is marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	) Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	)	
Maryland	Ment Ment narke	입	Philies Louis Cab	ana			Elvani	e Mar	ie Leto	ourneau	
Nar	shou h and 7 is n traum		19a. Informant's Name/Relationship (Type, Print)			ng Address (Street ar					
e,	le 1 and 2 t of Healt If item 2 or other 1		Geoffrey Forden/son  20a. Method of Disposition	20b Pi		rlton Road sition (Name of	<u>i</u> g <u>Mette</u>	Sley, Ma	assachuse	etts 02482  City or Town, State	
nor			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St	ate ce	emetery, cren	natory or other place	•				
Baltimore,	permit. Page Department Important: I any injury or		21. Signal re of Funeral Service Licensee	IL THE		rney Crema				e, Maryland	
B	permit. Departr Importa any inju	1	Muanta Rahoma	M0095	57 B	everly L.	Heckrot	on servi te, P.A.	. Clarks	Box 784 ville, MD 21029	
			23a. Part Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death	. Do not ente	er the mode of dying	, such as cardiac	or respiratory an	rest,	Approximate Interval Between	
	hysician/		Immediate Cause /Final		rombo	sis ā infa	arct			Onset and Death	
	Medical Examiner			as a conseque							
		-e	Sequentially list conditions, if any, leading to immediate Due to (or	as a conseque	ence off:						
	ed nsit	Examiner	Cause (Disease or iinjury	as a consequ	61106 01).						
	xecut n and al-tra	Exa	that initiated events c. Due to (or	as a consequ	ence of):						
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within Exp. 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	d								
68760	tificat ng ph as th	Me	IF FEMALE:								
9 x	th cer ttendi or use	ian/	23b. Was decedent pregnant 23c. If yes, outco	th 2 🗌 Fetal	Ideath 3	Ectopic pregnancy	,		23d. Date Mor	e of delivery hth Day Year	
Box	the a	Physician/M	1  Yes 2 No 4 Pregna 9  Unknown 9 Unknow	nt at time of de vn	eath 5∟	Other (specify)				an bay roa	
P.O.	at th		Part II. Other significant conditions contributing to dea	h but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contri	bute to the cause of death?	
S, I	lires the sign of	ed by	Pancreatic Cancer Stage	IV				1 🗆	Yes 2 ☐ No	3 Probably 4 Unknown	
ord	v requ	lete						24a, Was		Vere autopsy findings available	
Records,	he lav te has age 2	Completed			-			autor perfo	ormed? d	rior to completion of cause of leath?	
al F	an: T rtifica rtor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ce of Death (Chec		2 80 1101	2 103 2 2 110	
of Vital	hysica nis ce I direc	2	1 Yes 2 No	oatient 2 🗆 i	ER/Outpatier	ot 3 DOA Other	r: 4  Nursing H	ome 5 🗆 Resid	dence 6 🔀 Othe	r (Specify) Hospice	
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ion	tendideath tor: A	Certificate:	2 Accident Investigation	Imium, At ho	ma faum atu		Yes 2□No	005 1 1 1	24	Devel Devile Aliverhau	
Division	after after Direction by	S		etc. (Specify)		eet, factory, office		City or Tou	vn, State)	r or Rural Route Number,	
	spita hours neral	Medical	29a. Certifier 1 😾 Certifying Physician: To the bes								
	he Ho in 24 he Fu pleter	Med	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: To								
_	Vith Com		29b. Signature and title of certifier  J. iCoucus che (	1. ~	n	29c. License		7		(Month, Day, Year)	
			J. Reactive to		, ,	100.	3742	<u> </u>	Februa	ry 4, 2010	
	20 V		30. Name and address of person who completed cause								
	Sta	te		JUT Mur įstrar's Signati		r Mill Roa	ad Rock	ville, 1	Maryland	20855	
	Registr		FFR 0 0 2010		1 1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Items 20a-c per fh 8900 2-17-10 vt.

State of Maryland / Department of Health and Mental Hygiene

			for State	ate of Maryla		epartment of H Certificate of L			gierie Reg. No.	00011
			Registrar     Decedent's Name (First, Middle, Last)		`	oortmoato or a		2. Date of Dea	th 2011	3. Time of Death
	Physicia /Medic		William K. Fre	e				Feb.	5, 2010	1:00pm M
_	Examin		4a. Facility Name (If not institution, give street	and number)			Location of Death		4c. County of Deat	
- 2			706 Earlton Road  5. Social Security Number 6. Sex	7. Age (In y	e last hirth		erstown If Under 24 Hrs.	8. Date of Birtl	Baltimoi	hplace (State or Foreign buntry)
	Funeral Director		215-42-3070			rs. Months Days	Hours Min.	(Month, Day Oct. 17	, Year) Co	cyland
	0		Usual Residence of Decedent  10a, State 10b, County	100	City Town	or Location				10d. Inside City Limits
	taryla show	ō				erstown				1 ☐ Yes 2 📉 No
	the N 28a-f	Directo	Maryland Baltimore  10e. Street and Number		(6136	10f. Zip Code			10g. Citizen of What Co	ountry?
3	n with	al Di	706 Earlton Road			21136			United Sta	
i.	ems a	Funeral	11. Marital Status 12. W	as Decedent Ever in	U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14. Race - Ame Black, Whit	
0000	rs afte	by Fu	TT.	X Yes 2 ☐ No Yes, Give ear or Dates:		i 1 □ Yes 2X No	Specify:		Specify: WI	nite
3	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Armarked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade con	nnieted)	16a.	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work	ina	16b. Kind of Business.	/Industry
7	/ithin / ne. han "r e Med	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+) 4 Years		orts Writer			Baltimore	Sun
7	filed with Hygiene. Sther thai	CO	12 Years	4 leals	ър	Olts Wilter		e (First, Middle,	Maiden Surname)	
yland	should be to and Mental in marked oumatic even	To Be	Charles E. Free				Geneviev	re	Ramsbu	rg
a	2 should be and Mental is marked craumatic even	-	19a. Informant's Name/Relationship (Type. F			Mailing Address (Street				Zip Code)
€	1 and 2 Health tem 27 i		Brett Free	(Son)		28 Sharptow	n Road I	laurel,	DE 19956 20c. Location - City or	Town State
_	0 0		20a. Method of Disposition  12 Durial 2  Cremation 3 □Remo 4 □Donation 5 □ Other (Specify)	val from State	cemeter arrol	Disposition (Name of y, crematory or other place Cremation	, Inc., 17	Date /	Hampstead Creagerste	
Бант	permit. Pag Department Important: I any injury o		21. Signature of Euroral Service Licensee		Luage	22. Name and Addre			Reistersto	
ñ	an)			yne Oster		ELINE FUNE			erstown, MD	21136
		1	23a. Part1. Enter the disease, or complication shock, or heart failure. Hist only one care			not enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
m.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	terilor		- 6\ "		<u> </u>		
<b>L</b>	Examiner			Due to (or as a cons	ca l	Jigous				
	2 ×	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence	of):				
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58/60,	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	alE	L <sub>d</sub>	,						
20	tificate ig phy as the	ledical								
X R O	leath certific attending p I for use as 1	an/N	23b. Was decedent pregnant	f yes, outcome pf pre 1□Live birth 2□F	etal death		у		23d. Date of de Month	elivery Day Year
9	he dea	Physician/M	1 Voc 2 No	1□Pregnant at time 9□Unknown	of death	5 ☐ Other (specify) _				
٠ <u>.</u>	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contribu	uting to death but not	resulting ir	the underlying cause given	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
rds	equires en sign suld be							1 🗆	Yes 2 No 3 F	Probably 4 Unknown
Vital Records,	law re nas be	Completed						24a. Was	nsy / prior to	autopsy findings available completion of cause of
								perfe 1 Yes		s 2 No
	Physician: r this certifica ral director, p	Be C	25. Was case referred to medical examiner?  1 Yes 2 No Hosp	ital: 1 🗆 Innatient	2 FJ FB/OL	utpatient 3 DOA Oth	26. Place of Dea		one) idence 6 □Other (Sp	recify)
0	g Phys er this eral dii	n: To	27. Manner of Death	8a. Date of Injury (Month, Day Yea	28b.	Time of 28c. Inju			how injury occurred	
Sior	Attending I r death. ector: After by the funer	atio	↑ Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 No			
Division or	I or Attencate after death Director:	Certification:	3 Suicide 6 Could not be determined 2	8e. Place of injury - / building, etc. (Sp		arm, street, factory, office		City or To	(Street and Number or I wn, State)	Hurai Houte Number,
	spital	aCe	29a. Certifier 1 Certifying Physicia	n: To the best of my	knowledge	e, death occurred at the t	ime, date and place	e, and due to the	e cause(s) and manner	as stated.
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by	Medical	one)	and manner stated.	imiauon al	29c. Licen			29d. Date signed (Mo	
	To To Co⊓	Σ	29b. Signature and title of certifier	0-01/4			5602		Z / 10	s
			30. Name and address of person who comp	eted cause of death	(Item 23a)		-		-1,1,	* ,
1			John H. Eppler, M.I				O Towson,	MD 21	204	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1 6.01				
4	Regist	rar	FEB 0 8 20	10 Clever	n p	. park				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Daniel February 2010 3:45 $\mathbf{P}$ M Μ. Garmize 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Numbe if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **March 8** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 **X** M 2 □ F Year 1967 Idaho 214-02-9880 42 Usual Residence of Deceden 10b. County 10c. City, Town or Location Howard Ellicott City 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3450 Arcadia Drive 21042 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Property Support Services Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Μ. Garmize Doris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris T. Garmize, mother 7490 Hickory Log Circle Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory, Inc. 02/09/10 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, 21. Signature of Funeral Service Licensee George MacNabb Leon 299 Frederick Road Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Alcoholic End Stage Liver Disease disease or condition resulting in death) Due to (or as a consequence of): Hepatorenal Syndrome Due to (or as a consequence of) Coagulopathy Due to (or es a consequence of) 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

Be

Examiner

**Funeral** 

Director

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ral", or items 23a or 28a-f sho Examiner must be notified at

"natural", or items 23a

al Hygiene.

should be file and Mental F is marked of

permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau

the Medical

hours after

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

death

within 24 hours after death

To the Funeral Director: /

law requires that the death certificate be executed and tran attending physician a for use as the burialsigned by the a d be detached fo been si should I as 2 page To the Hospital or Attending Physician; The After this certificate funeral director, pag

Examine Physician/Medical Completed by Be မ Certificate:

Medical

(Check

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\overline{\mathbf{W}}$  Other (Specify)  $\overline{\mathbf{Hospice}}$ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Koucetchou,

29c. License number 563748

29d. Date signed (Month, Day, Year) February 9, 2010

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road Rockville, MD 20855 Jocelyne Kouatchou, M.D.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edna S. Gasse1 February 8, 2010 10:38 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Min. Hours Months Pennsylvania July 9, 1924 Director 205-14-7622 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Harford Abingdon 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 504 Ramblewood Drive, Apt. 305 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2X No Specify: Specify: White 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Liss Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 73 Perry Falls Place Nottingham, MD Robert I. Gassel, son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/09/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD,

299 Frederick Road Raltimore MD 213 Selg 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of): attending physician and for use as the bunial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA ျပ To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 X Certifying Physician: To the best // y knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis // examination and/or investigation, in my opinion, death occurred at the time, date and place  Medical 29a. Certifier Medical Exeminer: On the basis / examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Pertifying Nurse Practioner: T, he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) pper Chisapeake Dr. Bel Lic, mo 21014 State FEB09 Registrar

DHMH 17 Rev 7/2009

in 72 hours after death with the Maryland	/Medical Examination of the state of the sta	
in 72 hours after death	n "natural", or items 23a or 28a-f show Wedical Examiner, rust be motified at	ploted by Europeal Disoptor

Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death N/A 443 ELRINO ST. BALTIMORE 8. Date of Birth (Month, Day, Year) 02/13/1930 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs, last birthday) Days Hours 1□ M 2√ F Months Min. 212-28-9241 79 MD. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 √Yes 2 No MD. N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 UNITED STATES 443 ELRINO ST. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Yes. Give WHITE 3X Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH College (1-4or 5+) Com permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important; If item 27 is marked other tha any Injury or other traumatic event, Iru. CASHIER HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE H. VING JENNIE CARLSON မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 443 ELRINO ST., BALTIMORE, MARYLAND BRIAN GRUPP/SON 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 02/07/2010 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES SORZEILER & SON, 2INC BALTIMORE, MARYLAND, 2I224 6224 EASTERN AVE., 23a. Part 1. Enter the diseas, or complete ons that caused the death, shock, or heart failure. List only one cause on each line. nter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examine drany, leading to inchedie cause. Enter Underlying Cause (Disease or injury that initiated events led by the attending physician and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 1 ☐ Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 \(\to\) Nursing Home \(\frac{3}{\top-Residence}\) Residence \(6 \subseteq Other\) (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nd address of person who completed cause of death (Item 23a) (Type, Print Year) State Registrar

10-01068 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael Guthridge 03315 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Da Madical Examiner Michael David Guthridge 0555 hrs February 6, 2010 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Baltimore County** 4361 Ebenezer Road Perry Hall If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Davs Director April 21,1969 country) Maryland 1 X M 2 F 40 216-06-1343 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any. 10a. State 10b. County Nottingham Baltimore Md. 1 Yes 2 X No 28a-f shov "natural", or items 23a or 28a-f shov | Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21236 8 Sylvanhurst Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 X Married 1 X Yes 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 hours 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na injury or other traumatic event, the Medical Ex Elementary/Secondary (0-12) College (1-4 or 5+) Comic Book Store Entrepeneur/Owner 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Patricia Talley Jacob Guthridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nottingham, Md. 21236 8 Sylvanhurst Court Spouse Christi C. Guthridge 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 2-13-2010 Middle River, Md. Holly Hills 4 Donation 5 Other Specify: 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Buin a. Nottingham, Md. lu 9705 Belair Rd. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic cardiovascular disease complicated Physician Between Onset and /Medical Immediate Cause (Final disease cardiovascular disease by head injuries a Atheroselerotic Éxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Physician/Medical 23a,2/,28a-t, per ME g901 3/19/10 TT X AMENDED 23a,27, permE, g900 2/22/10 TT X UNPENDED certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. è Yes 2 No 3 Probably 4 ✓ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes director, 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural subject fell Yes 2 No Pending |Fd 5:00 am Fd 2/6/10 2 X Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State #361 Ebenezer Road

Death

Year

Perry Hall, MD

29d. Date signed (Month, Day, Year)

February 7, 2010

ospital or Attending Physician: hours after death Division

To the Funeral Director: completely filled in by the Hospital (

31. Date filed (Month, Day, Year) State FEB 09 Registrar

Ana Rubio MD.

3 Suicide

Homicide

29b. Signature and title of certifie (MOL

> 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registrar's Signature arked

store

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

6 | Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ f管BRUARY 7, 2010 GHOLIAN 04:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7105 BOXFORD ROAD BALTIMORE CITY N/A 5. Social Security Number 6. Set 1 M 2 D F . Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Τ D Λ N **Funeral** Months Hours 642471929 214-33-5665 80 IRAN **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 □ No MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7105 BOXFORD ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE "natural" Completed 3 Divorced Year or Dates other than "natu ent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **BOOKKEEPER** GARMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic ever မ MAYER GHOLIAN GOHAR UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 7105 BOXFORD ROAD, BALTIMORE, MD GHAMAR GHOLIAN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o AGUDATH ISRAEL CEM. 2/8/2010 ROSEDALE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. re of Funeral Service Licen 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, CARDIO-DULMOUN MMENIATE Medical resulting in death) Examiner COROWAND year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending prefetached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t page 2 s autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After 1 Natural 2 Accider 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 025039 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) JAKO BOLL JMITH MD 21209 Ulifu 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 03317 Erik Lee Guinn State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 2, 2010 0242 hrs Medical Examiner Lee Guinn Erik 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Country) Days MD Director May 3, 1973 212-82-9758 36 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 0b. County s 23a or 28a-f show e notified at once. Baltimore Catonsville 1 Yes 2 X No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 USA 2203 Edmondson Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after or Department of Health and Mental Hygeine.
Lipportant: If iten 27 is marked other than "natural", or injury or other tranmatic event, the Medical Examiner or injury or other tranmatic event, the Medical Examiner. specify: white 3 Widowed 4 Divorced f Yes, Give Year Yes 2 X No specify: ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) machinest manufacturing 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanne Hurdel Curtis Lee Guinn Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2203 Edmondson Ave., Catonsville, MD 21228 Jeanne Hurdel (mother) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State All County Cremation 2-10-10 Sykesville, MD Donation 5 Other Specify. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses House Haight a P.O. Box 195 Sykesville, MD 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease of injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical physician a UNPENDED AMENDED Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 ned by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ð 1 Yes 2 ✓ No 3 Probably 4 Unknown σ. Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: Vital Be Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 2 ER/Outpatient 3 this 1 Yes é 28a. Date of Injury (Month, Day, Year) Feb 1, 2010 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death Certification: Pedestrian struck by auto 2354 hrs Natural Division Director: / 1 Yes 2 V No 5 Pending 24 hours after death. 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) Route 40 and Charing Cross Road, Baltimore, MD determined (Specify) Major Road Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie February 3, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ 2010 Donald Norris Haves 8:45 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1409 Oakview Drive Montgomery Silver Spring Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec 6, 1931 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Days Hours Washington, 577-42-4026 **Director** 78 Usual Residence of Decedent 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Directo 1 Tes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code è 10g. Citizen of What Country? Funeral 23a 1409 Oakview Drive 20903 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 🔀 Married ò Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural", 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Municipal Bond Trading t of Health and Mental Hyg If item 27 is marked othe or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ralph Joy Hayes Kathleen Mae Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret H. Hayes/wife 1409 Oakview Drive Silver Spring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If ii any injury or c 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 2/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signalus of Funeral Service Lice 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 Rypomas M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Atherosclerotic Cardiovascular Disease years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to lor as a consequence of It any leading to in medicause. Enter Underlying Cause (Disease or linjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2🗶 No or Attending Physician: after death. Director: After this certific I in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify, မ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated actioners to the basis of the truly knowledge or attraction date in distance and place and place and place. (Check Certifying Nur Practioners To the best of the knowledge direct 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D19431 February 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Frank M. (Ryan,

31. Date filed (Month, Day, Year)

M.D

DHMH 17 Rev 7/2009

11701 Livingston Road, Suite 103 Ft. Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Feb <sup>Day</sup> 2010 3:30 A<sub>M</sub> Catherine Hoy 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 212 F 182-01-9989 92 Director Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Carroll 1 ☐ Yes 2 ☑ No MD Westminster Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Modical Examiner must be a 903 Alexander Dr. 21157 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white ð 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas J. Scully Kathryn A. Mahoney မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type\_Print) Robert C. Hoy Jr.-son 903 Alexander Dr., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John Cemetery 2-13-2010Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Sign tur of 50 eral Service Lices - Comas 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -2/6/1 **Physician** 100 disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Ye ar Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed 2 UN6 1 ☐ Yes 2 No ours after death.

eral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Stother (Specify) DON E 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 1/2001

State Registrar South Couter Street Was Tmisster, 43 21157

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 0.9

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03320 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 6, Physician/ 2010 6:28 P PAULINE A **HOEFLICH** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE BALTIMORE 9. Birthplace (State or Foreign Country) PA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral 1 M 2 T F Days Hours 5/26/1937 166-32-3938 72 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ¥ No MD BALTIMORE TIMONIUM 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? Funeral 403 PLUMBRIDGE COURT, #401 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry BALTIMORE COUNTY College (1-4 or 5+) Elementary/Seconday (0-12) COUNSELOR PUBLIC SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HARRY L HOFFMAN ROSE ZACKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 PLUMBRIDGE COURT, #401, TIMONIUM, MD 21093 BETTY PATTERSON/EXECUTOR 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State OHEV SHOLOM CEMETERY 2/9/2010 LEWISTOWN, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Acense 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ cavanima woo disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant a Pregnant at time of death io the Funeral Director. After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached i P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed. Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Silice Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D68286 te brucin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FFR 0 9 2010

32. Registrar's Signature

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6701 N. Charles St baltimore, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown 8. Date of Birth (Month, Day, Year) Sep. 18, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Hours Min. Months 212-90-2776 1**√2** M 2 □ F Days 44 Yrs 1965 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll MD Mt. Airy 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 429 Twin Arch Road 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Landscape 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert C. Sonifrank Gladys Honeycutt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Dawn Wright / Fiancee 429 Twin Arch Road, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 2/10/2010 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Euneral Service Licensee Dorota Marshall PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) □Yes 2□No 9 Unknown ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital:  $1 \square$  Inpatient  $2 \square$  ER/Outpatient  $3 \square$  DOA 1 ☐ Yes ZX No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Box 68760 Ö Records, of Vital

Physician /Medical

Examiner

**Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnice.

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Certification: To

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that the death certificate be executed Division

The Physician: Hospital or Attending death. nours after death, neral Director: / / filled in by the fo 24 hours a Funeral I

> State Registrar

DHMH 17 Rev 1/2001

Year)

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (1

and manner stated.

1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19a per fh.g900.02/18/2010dhb

Amend Item 23a per dr.g900.02/19/10dhb For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edna Florence Hoffman 5:20p 2010 Medical January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ┰ F Months Days Hours (Month; Day, 214-22-4401 96 **Director** 1913 Aug MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1X□ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1408 Patapsco Street 21230 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Yes. Give 1 ☐ Yes 2 🙀 No Specify: Specify: white Completed 3 XWidowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Phillip Kotmair Katherine Agnes Murray 19a. Informant's Name/Relationship (Type, Print)

Tohn W. Hoffman, Jr. - son

Trancis X. Hoffmah (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10305 Spruce Way, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 1 - 26 - 10Sykesville, MD County Cremation Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daigu Haight of erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) Acute Medical **Examiner** Chronic Renal Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examiner Dementia Due to (or as a consequence of): resulting in death) Last Physician/Medical ECLING HOLLING IN Sox 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ျ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29d, Date signed (Month, Day, Year) D Kasy ss of person who completed cause of death (Item 23a) (Type, Print) 2300 Valley Rd. Timonium, MD 2143 DUIGDRY 32. Registrar's S nature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 3Î<sup>y</sup> 2010<sup>°°°</sup> HOFFMAN 4:15 A M SYLVIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PIKESVILLE BALTIMORE 725 MT. WILSON LANE, Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 🗆 M 2 🗓 F Months Days Hours 1072771920 Director 220-05-4591 89 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE PIKESVILLE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21208 USA 725 MT. WILSON LANE, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?, 1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SIMON HONICK ROSE FELDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRED HOFFMAN / HUSBAND 725 MT. WILSON LANE, #407, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) REISTERSTOWN, MD BALTIMORE HEBREW CEM. 2/5/2010 21. Sign ture il Funeral Service Lice ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ DEMON719 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Little Underlying Cause (Disease or iinjury Exami SFIERE been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year g 🗍 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law i within 24 hours after death.

To the Funeral Director, After this certificate has be completed filled in by the funeral director, page 2 s autopsy performed 2 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Accident Investigation ☐ Acciuei ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 7/2009

State

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year, 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month epilary Physician/ Olsev 2010 21:54 PM Ulam Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death n/a Bon Secour Hosp. Baltimore If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Mar. 23, 1 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Days Hours Min. 216-58-3308 56 Director Yrs 95 Usual Residence of Decedent or 28a-f show 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director Baltimore n/a MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21213 1618 E. Chase St. th and Mental Hygiene. 27 is marked other than "natural", or items 23s traumatic event, the Medical Examiner must I USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces' Black, White, etc. 1 X Never Married 2 Married ģ 1 Yes 2 No If Yes, Give within 72 hours after 1 ☐ Yes 2 A No Specify: Specif**B**lack 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed yrs Plumber Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Ella Foster Willie L. Hosley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (*Type, Print*) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Hosley Griffin (sister) 4027 Belwood Ave. Balto, Md. 21206 Department of Health a Important: If item 27 is any injury or other trai 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery Feb.11.2010 Balto, Md. \_Donation 5 Other (Specify) Sonature of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home Preston St. 1412 E Balto. Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death acute Pancreatitis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Falure 1 Yes 2 No 3 Probably 4 Unknown page 2 should VIIUS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Immunual CARCU 24a. Was an autopsy performe Hospital or Attending Physician: The Yes 2 N 25. Was case referred to medical examiner?

1 ☐ Yes 2 ► No Be 26. Place of Death (Check only one) ျ 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 nly one) 296. Signature and title of dertifier 45148 udical travse Othicer of person who completed cause of death (frem 23a) (Type, Print) Name and addr

State Registrar icar 100

31. Date filed (Mont

SOYNO

Baltimore, Maryland 21215-0036

Box 68760

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Division of Vital

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2000 West Bultimora

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death JAMUEL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE AT NORTHWEST HOSP. RANDALLSTOWN BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/20/1921 Birthplace (State or Foreign Country) ROMANIA Hours 216-28-3634 88 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 24 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 TEFFY DRIVE, #C USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🕱 Married 1 □Yes XXNo WHITE Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BAKER 12 BAKERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOSEPH** ISAK MALKA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILI ISAK/WIFE 2901 TERRY DRIVE, #C BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 02/08/2010 4☐Donation 5 ☐Other (Specify) RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service ( 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 art1. Enter the disease, or or mode is that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. mere Approximate Interval Between Onset and Death Immediate Cause (Final Ancrea disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, and be a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disable (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? autopsy 1 □Yes 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of Death Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**Physician** /Medical Examiner

be executed

The law requires that the death certificate

P.O.

Division of Vital Records,

To the Hospital or Attending

within 24 hours a

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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**23**a

er than "natural", or items

7 is marked other traumatic event, I

Department of Health a Important; if Item 27 is any injury or other trau

be notified at

Director

Funeral

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Completed

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the Maryland

Pages Land 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner page 2 s

sician and burial-tran anding physician use as the buria Physician/Medical been signed by t should be detach ģ Completed after death.

Director: After this certific Be Certification: To filled in by

25. Was case referred to medical examiner

29a. Certifier

(Check only one)

Medical

2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completed cause of death (Item 23a

31. Date filed (Month, Day, Year)

State Registrar



10-00988
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Please Type or Print in Black Indelible Ink. Figure All Copies Are Legible

Jordan Jackson-V	1	- For State	te of Maryla	ind / Depai				ygiene	20	110 0332		
Physician	n/ 1	egistrar I. Decedent's Name (First, Middle	Last) /	1		,	-	2. Date of Dea		3. Time of Death		
Medical Examine	-	Ia. Facility Name (if not institution,			DN-1	1EGA		Month February		0/55 nrs		
		Union Hospital	give street and num	inder)		b. City, Town, or I Elkton	Location of Death	1	4c. County of Cecil	Death		
Funeral	5	Social Security Number	S. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year		_		9. Birthplace (State or		
Director	2		1 M 2 F		Yrs	Months Days	Hours Min	12-23	-2009	Foreign Country)		
S dub	_	Jsual Residence of Decedent  0a. State 10b. County	,	10c. City, T	own or Locati	on		• (		10d. Inside City Limits		
<u> </u>	٦	Mb CEL	CLF.	EL	KTON					1 Yes 2 No		
Maryla	Ulrector 1	0e. Street and Number	_		100/9	10f. Zip Code			10g. Citizen of Wha	at Country?		
ith the		98 KIRK 1. Marital Status	KD		140 111	219	21		YES	>		
leath w	តា	1 Never Married 2 Man	ried Armed For	edent Ever in U.S rces? 2 No	. 13. Wa	Decedent of Hisp es, specify Cuban,	mexican, Puerto	ecify Yes or No Rican, etc.)	White,			
after d	ٰٰٰٕ		1 Yes  Ced If Yes, Give Year  or Dates:		1)区	Yes 2 No	specify:		Specify:	ZIO RIGAN		
hours "natur		<ol> <li>Decedent's Education (Specif Elementary/Secondary (0-12)</li> </ol>	y only highest grade College (1-			's Usual Occupationst of working life.			16b. Kind of Busi	ness/Industry		
036 thin 72 than tedical	ompieted	O Contains (0-12)	College (14	4 (1 3+)								
15-0036 Tiled within 7 Hygiene. d other than	′ إ د	7. Father's Name (First, Middle, L	ast)			1	B.Mother's Name	(First, Middle,	Maiden Surname)			
2121 tould be fi d Mental I s marked tic event,		9a. Informant's Name/Relationship	ACKSOY	4	19h Mailing	Address (Street	TENER		mber, City or Town,	A State Zin Code)		
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Itiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	-	TENERIFE	VEGA	-	881	KIRK F	S	CON, I	10219 DZ19	121		
S l and of Heal	2	0a. Method of Disposition  Burial 2 Cremation	3 Removal from	20b. Pla	ace of Disposi ematory or oth	tion (Name of cemer place)	eterv	Date	20c. Location - C	City or Town, State		
timore,  The pages 1 a timent of He trant: If ite to or other trant.	4	Donation 5 Other Spec	cify:	•	VERBI	ECCK	2-	-2010	WILLAMIN	GRON DE		
Baltil permit Departm Importa	13	1. Signature of Funeral Service Li	censee		22. N	ame and Address	SNITH	FUNE	-	PULL		
Physician	2:	3a. Part I. Enter the disease, of co failure. List only one cause or	mplications that cau	used the death. D	o not enter th	mode of dying, s	such as cardiac o	r respiratory arr	est, shock, or heart	Approximate Interval		
/Medical Examiner		mmediate Cause (Final disease	a Sudden u		ned de	ath in i	nfancy			Between Onset and Death		
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g	if	equentially list conditions, any, leading to immediate duce. Eliter Underlying Cauco	Due to (or as a c	consequence of):								
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- o .o.c. to		X UNPENDED	AMENDED 23a, 27	7,28a-f,	per M	E G903 5	/26/10 I	T	-1 00 t B tt tf t			
ox 68760 anh certificate t attending physi or use as the bu	23	b. Was decedent pregnant in the past 12 months?	1 Live birt		2 Feta	death 3	Ectopic pregna	ncy	23d Date of de Month	Day Year		
Box 68760 e death certificate be the attending physical of for use as the but	1	Yes 2 No 9 Unkno		nt at time of death n	5 Oth	er (Specify)						
O t 2 2 2 0		art II. Other significant condition	s contributing to d	death but not resu	ulting in the un	derlying cause giv	en in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?		
S, P.(								1 Yes		Probably 4 Unknown		
Division of Vital Records, tal or Attending Physician: The law require is after death al Director: After this certificate has been siy led in by the funeral director, page 2 should be ertification: To Be Completed							<del> </del>	24a. Was autop	sy prio	ere autopsy findings available or to completion of cause of		
Rec The ifficate r, page		T.N.	-					1 Yes		Yes 2 No		
Vital ysician this cert directo		5. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inp	patient 2 🗸 EF	R/Outpatient	- 10	of Death (Check of ther Nursing		Residence 6	Other:		
of \ing Phi ing Phi Uneral	. 27	. Manner of Death	28a. Date of (Month, D	Injury 28	3b. Time of Inj				now injury occurred			
ivision I or Attend after death Director: d in by the f	2	Pending	Fd 2/3	3/10 F	d 7:30	am	s 2 X No	unk				
Division c spiral or Attending hours after death neral Director: Af filled in by the fun Certification	3	determin	or pe		e, farm, street in dwe	factory, office bui	Iding, etc.	28f, Location (S or Town, S	Street and Number of tate) 128 Vi	or Rural Route Number, City		
of Parity of Parity		la Cartifac										
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and due to the cause of the caus											
_   ≥			11	1/1/25	26	29c. License r	number		29d. Date signed	(Month, Day, Year)		
	29	b Signature and title of certifier	16-01/-	1/1	0	OCM	F		February 4 2	2010		
		Victor Sat	o completed cause	of death (Item 23	(a)	O.C.M	.E.		February 4, 2	2010		
	30	Name and address of person whe Victor Weedn MD JD	o completed cause Assistant Medie	,	,	O.C.M.		21201	February 4, 2	2010		
State Registra	30	Name and address of person wh	Assistant Medi	,	,			21201	February 4, 2	2010		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 1 per / doc 2900 2-09-10 vt
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Cei	rtificate of L	Death		Reg. No.	0 00007
	Physicia	an/	1. Decedent's Name (First, Middle, Last	00.0 W:	holo '	Johnson		2. Date of De	ath Day Yea	3. Time of Peath
	Medic	cal	4a. Facility Name (if not institution, give s		nere .			03	01 201	0   550 PM
	Examir	ner	university of r	naryland		Balty			4c. County of De	eath
	Funeral Director	١	110-40-1733	x	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl May 27		Birthplace (State or Foreign Country) BW York
	ihow at	5	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	e Maryla r 28a-f s notified	Director	MD Montgor  10e. Street and Number	nery		Takoma	Park			1 Yes 2 □ No
	h with th	Funeral	8305 Roanoke Ave			10f. Zip Code	20912		10g. Citizen of What United St	*
9600	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🄀 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, nite, etc. 31ack
21215-0036	ithin 72 ho ene. • than "nat he Medic:	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occupa kind of work done d O NOT use retired) Omemaker	ation furing most of work	ing	16b. Kind of Busines  Own Ho	
land 2	be filed wi ental Hygie ked other ic event, t	To Be	17. Father's Name (First, Middle, Last)  Roy  Danie				18. Mother's Name		Maiden Sumame) Frazier	
Mary	12 should be file alth and Mental I 27 is marked o ir traumatic eve	19	19a. Informant's Name/Relationship (Typer Telace Johnson /	pe, Print)			and Number or Rura	l Route Numbe	r, City or Town, State,	
Baltimore, Maryland	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery crer	esition (Name of natory or other place ce Cremate	a) i	Date /2010	20c. Location - City Beltsvil	
Balti	permit. Page 1: Department of I Important: If it any injury or of	-0	21. Signature of Funeral Service License	on Services	20910					
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused the death e cause on each line.						Approximate Interval Between
	Ph_sician/ Medical Examiner	i V	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		nditis				Onset and Death
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9289	tificate be executed ng physician and as the burial-transit	Medical Examiner	L.	d						
	death cer ne attendi ed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No g  Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	ncy I death 3 [ eath 5 [	Ectopic pregnanc	у		23d. Date of o	delivery Day Year
ls, P.O	ires that the signed by Id be deta		Part II. Other significant conditions con			nderlying cause giv				to the cause of death?  Probably 4 Vinknown
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Completed by	Diahetes		·				prior to death?	autopsy findings available o completion of cause of
EalF	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Check		2 <b>Y</b> No 1 □ Y	′es 2 □ No
Ž	Physic this ce al dire	은	1 LI Yes 2 Le No	ospital:			4 U Nursing Ho		lence 6 Other (Spe	ecify)
o uo	eath. or: After he funer	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		28d. Describe h	ow injury occurred	
Divis	ital or Att irs after d ral Direct led in by i		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Tow		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2   Medical Examinonly one) 3   Certifying Nurse	cian: To the best of my knowle er: On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred at	the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	No No		29b. Signature and title of certifier	1/ 1. 120		29c, License			29d. Date signed (Mor	nth, Day, Year)
	4		30. Name and address of person who co	mpleted cause of death (Item)	23a) (Type P		74435718	140	211/10	
	6		Paula Rosenbla	H ZZ 5	Gree		2+ Bal	hman	MD ala	01
	Stat Registra									,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 PMonth PEZZELAZ 11,200 Lucille V. Kris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deat BAGINGTZE WACHINGTON MENICH BURNIE ANNE CE MER Gira ARUDIDE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛣 F Months Days Hours Min. April 4.1916 93 390-07-0847 Director Wisconsin Usual Residence of Decedent 10a. State 10b. County with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No Anne Arundel Marvland Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 912 Hillcrest Road 21076 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates. WW II Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barnev Kuharske Theresa Sebert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald D. Kris, Son 912 Hillcrest Road Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 02/09/10 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Name and Address of Facility Of Maryland, 19 Frederick Road Baltimore, any Inc Maryland 21228 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician MEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi and Due to (or as a consequence of attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Date signed (Month, Day, Year) 45,146 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CIM HOC

State

Registrar

31. Date filed (Month, Da) (ear)

FEB 0 9 2010

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OM AG ٥ Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F Months Days Hours Min 8-11-1945 215-44-1503 64 Director MD Usual Residence of Decedent or 28a-f shov Director 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at MD Anne Arundel Severn 1 Yes No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 8032 Quarterfield Road Severn USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examitiany in Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Steven Krupnik Julia Witkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Krupnik/wife 8032 Quarterfield Rd. Severn MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2/8/2010 Glen Burnie, MD 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA Signature of FSN, ral Service Licer 421 Crain Hwy SE Glen Burnie MD 21061 M01365 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Debt Immediate Cause (Final disease or condition Ph\_sician/ Medical resulting in death) Examiner Sequentially list conditions cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be lirector, page 2 s autopsy Yes 2 No 1 Yes 2 No B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

neral Director: / filled in by the f within 24 hours a

To the Funeral C

completed filled i

29a. Certifier (Check only one)

Medical

Suicide

Homicide

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number

30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print)

DEXENSE HIGHWAY ANNAPOUS MD 21401 aPENTA m MICHAEL

31. Date filed (Month, Day, Year) State

6 Could not be

determined

32. Pogistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland	d / Depa <i>Cer</i>	artment c tificate c	of Health of Death	and M	lental Hy	giene Reg. No		03330		
ì	Physicia	n/	1. Decedent's Name (First, Middle	, Last) Ann Kelly						2. Date of De			3. Time of Death		
	Medic Examir		4a. Facility Name (if not institution	give street and number)				n, or Location	of Death	1-espina		County of Dea	ath		
-	, 		4009 Belle of (		ie (In yrs. las	t hirthday)	Pa If Under 1 Y	sadena	er 24 Hrs.	8. Date of Bir			e Arundel		
	Funeral Director		214-54-8276	1 □ M 2 💢 F	60	Yrs.	Months Da		Min.	1-19-1			rthplace (State or Foreign ountry) MD		
	and show	ē	Usual Residence of Decedent  10a. State 10b. County			Town or Loc							10d. Inside City Limits		
	e Maryl r 28a-f notified	Director	MD Anne  10e. Street and Number	Arundel		Pasade							1 🗆 Yes 2 🔀 No		
	with the 23a or	Funeral I	4009 Belle of	Georgia Ave	•		10f. Zip Cod 21	122			10g. Ci	itizen of What C	ountry?		
336	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	11. Marital Status  1 □ Never Married 2 □ Mari 3 □ Widowed 4 ☒ Divorced	100 2	Ever in U.S. No	If	Vas Decedent Yes, specify O ☐ Yes 2 🛛	uban, Mexica	an, Puerto	cify Yes or No- Rican, etc.)		erican Indian, te, etc. hite			
2-0	2 hours "natur edical I	Completed		nt's Education st grade completed)			ent's Usual Oci ind of work do		st of workii	na	16b. k	Kind of Business	s Industry		
2121	within 7 giene. er than the Mo		Elementary/Seconday (0-12)	College (1-4 or 8	5+)	life. DC	NOT use reti inageri	red)		.5		Govern	ment		
Maryland 21215-0036	d be filed v Aental Hyg arked oth rtic event,	To Be	17. Father's Name <i>(First, Middle, L</i> John Calhour	,	on					e (First, Middle, eth Jo		Surname) tson			
, Mary	nd 2 should salth and N n 27 is me er trauma		19a. Informant's Name/Relationsh Kathryn E. Spei	1 1 21 -		19b. Mailin	g Address (Str Alta V	eetand Numb ista D	per or Rura r Mil	Route Numbe lersvi	r, City oi	r Town, State, Z MD 2110	ip Code) 8		
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State	cer	metery, crem	-	niace) i		0ate 2010		ocation - City o onsvill			
Balt	permit, Page Department of Important: If any injury or once,		Catonsville MD   Cato												
	Pnysician/ Medical Examiner		23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, b.												
8 09	icate be executed physician and sthe burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as d.											
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: ,23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pregr Other (specify	ancy				23d. Date of de Month	slivery Day Year		
ls, P.C	uires that in signed build be deta	by	Part II. Other significant condition	ns contributing to death b	ut not resul	ting in the ur	iderlying cause	given in Par	t I.				o the cause of death?  Probably 4 Tunknown		
Division of Vital Records,	<b>sician:</b> The law rec certificate has bee irector, page 2 sho	Completed							W 100	24a. Was autor perfo 1 \(\sum \) Yes	Sy	prior to	utopsy findings available completion of cause of		
ita	sician: certific irector,	Be	25. Was case referred to medical examiner?  1   No Yes 2 □ No	Hospital:				. Place of De		only one)					
on of V	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	cate: To	27. Manner of Death  1 Natural 5 Pendin 2 Accident Investig	28a. Date of inju (Month, Day	ry 2	R/Outpatient 8b. Time of injury	28c, II	4 ⊔ N njury at vork? □ Yes 2 □	2	me 5 🔏 Resid		Other (Spec y occurred	cify)		
Divisio	al or Atte	Certificate:	3 Suicide 6 Could 1 4 Homicide determ	not be 280 Place of Inju		e, farm, stre	et, factory, offi	се	2	28f. Location (S City or Tow			Iral Route Number,		
	the Hospii nin 24 hour the Funera	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of e Nurse Practioner: To the	xamination a	and/or investi	gation, in my or	pinion, death of	occurred at	the time, date a	nd place	and due to the	cause(s) and manner stated.		
7	To with		29b. Signature and title of cyrtifier	mo			29c. Lice	057(7)	4			te signed (Mont	h, Day, Year)		
	10		30. Name and address of person of Scott Zaff will	who completed cause of d	eath (Item 2	3a) (Type, Pr		iadena	M	2113	.2.				
	Stat Registra														

DHMH 17 Rev 7/2009

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Plea	se Type or Prir				-	_			
			For State Registrar	State of Ma	aryland / L	Department of <i>Certificate o</i>			ene g. No. 201	0 0333		
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of Death		
	Physicia		Sybil Diana K	ime				January	16, 2010	9:08 AM M		
	/Medic		4a. Facility Name (If not institution			4b. City, Town	, or Location of Death	1	4c. County of Dea	th		
			9794 Martingh	am Circle D1		St. 1	ichael's		Talbot			
	Funeral Director		5. Social Security Number 217–38–5686	6. Sex 7. Ag	e (In yrs. last bil 80	rthday) If Under 1 Yea Yrs. Months Day		8. Date of Birth (Month, Day, July 16,	Vear) Co	thplace (State or Foreign ountry) diff U.K.		
pL			Usual Residence of Decedent		10 02 T					10d. Inside City Limits		
aryla	shov at p	ž	10a. State 10b. County		10c. City, Tow					1 □Yes 2 No		
e M	8a-f	ectc	MD Talb	ot	St.	Michael's		T 10	g. Citizen of What Co	41		
with t	3a or 2	Funeral Director	10e. Street and Number 9794 Martingha	m Circle Dl		10f. Zip Cod	21663	10	USA	oundy?		
deat	E E	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, Whit			
filed within 72 hours after death with the Maryland	al", or ite Examina	þ	1 ☐ Never Married 2 ☐ Marr 3 🛣 Widowed 4 ☐ Divorced	ied Armed Forces? 1 □Yes 2X I If Yes, Give Year or Dates:	No	1 ☐Yes 2MA		o moan, etc.,	Specify: W			
in 72 ho	n "natur Aedical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or 5		. Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	ne during most of wor		6b. Kind of Business	/Industry		
with	giene rrtha	E O	12	5+	,+)	physici	an		healthcar	е		
e file	al Hy othe	Be (	17. Father's Name (First, Middle,	Last)				ne (First, Middle, M	•			
q pin	Ment rrked rtic e	To	Albert Grange	r			Edi	th Vining	3			
sho	and I		19a. Informant's Name/Relations	hip (Type. Print)		o. Mailing Address (Stre			-	Zip Code)		
and	n 27 i		Karen Hershfe	ld/daughter	_	3214 Oaklan				21550		
Pages 1	Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S.		20b. Place o cemete	of Disposition (Name of ery, crematory or other p	elace)	Date 2	oc. Location - City o	Town, State		
permit.	Departn Importa any Inju		21. Signature of Funeral Service Ronal d	Licensee de, Dir	ector	State And Baltimore			Baltimore	Street		
			23a. Part 1. Enter the disease, or	complications that caused	the death. Do		,		st,	Approximate Interval Between		
Dh	ysician		shock or heart failure. List Immediate Cause (Final			TES TINAL	BLEEDIN	JG		Onset and Death		
	Medical		disease or condition resulting in death)	a	a consequence		72000-11	- 1				
Ex	aminer					,						
T		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
executed	nd ransi	Examiner	that initiated events	С								
	ian a ırial-t	_	resulting in death) Last	Due to (or as	a consequence	of):						
ate b	hysic the bu	lica		d								
ertific	ling p	Mec	IF FEMALE:									
Attending Physician: The law requires that the death certificate be	attending physician and for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal deatl	h 3 🗆 Ectopic pregn 5 🗆 Other (specify			23d. Date of de Month	elivery Day Year		
the de	/ the	ysic	1 □Yes 2 🏝 No 9 □ Unknown	9 Unknown	at time of death	3 🗆 Other (apeciny						
that	deta		Part II. Other significant condition	ons contributing to death b	ut not resulting i	in the underlying cause	given in Part I.	23e. Did tob	acco use contribute	to the cause of death?		
uires	as been signed by the 2 should be detached	d by						1 □ Ye	s 2 2 No 3 □ F	Probably 4 Unknown		
w red	shou	Completed						24a. Was ar		autopsy findings available		
he la	te has	d w						autopsy	ned? death?	completion of cause of		
an: T	tificat or, pa		25. Was case referred to medical	<u> </u>			26. Place of Dea	1 ☐ Yes 2 ath (Check only one		S Z LINO		
ysici	s cer direct	To Be	examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 ☐ Inpati	ent 2 ER/O	utpatient 3 DOA	Whor:	4	nce 6 ☐Other (Sp	ecify)		
F F	ter th	Ë	27. Manner of Death	28a. Date of Inju (Month, Da	ury 28b.	Time of 28c. I	njury at Vork?	28d. Describe ho	w injury occurred			
andin	ath.	atio	1 Natural 5 Pendin 2 Accident investi	gation	,,,,,,,,		□Yes 2□No					
l or Atte	after de Directo d in by tf	Certification:	3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State)									
Hospital	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Co		ng Physician: To the best Examiner: On the basis of and manner st	of examination a							
o the	vithin o the ompl	Me										
F	> P 0		1 Phint	-1111		D	057108		2/1/10			
			30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)						
			KIBENT	J. PATTE	1250N	8005, TAZ	130T ST	ST MIC	HABIS W	10		

State Registrar 31. Date filed (Month, Day, Year)
FEB 0 9 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per ME g900 2/25/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 1. Decedent's Name (First, Middle, Last) - Month **Physician** /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (in vrs. last birthday) **Funeral** 1 🗶 M 2 🗆 F 83 1926 July 8, Pennsylvania 723-09-0620 Director Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No MD Director Howard Ellicott City 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number items 23a 10114 Century Drive 21042 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No If Yes, Give Year or Dates: 444— 14. Race - American Indian, 11. Marital Status Black White etc injury or other traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Ite 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 3 Widowed 4 Divorced 44-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Lea Shaw Richard Crittendon Knox ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any injury or other trau once. 10114 Century Drive Ellicott City, MD Evelyn Knox/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final intracerebral **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed CERTIFICAT and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ate has been signed by the atten page 2 should be detached for in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year 5 Other (specify) Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has perform 2 No 2 No or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner Hospital: 1 Impatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) မ filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury Certification: (Month, Day Year Injury 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hound to the funer completely file Medical (check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D67406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo ohD 600 North Wolfe St, Baltimore, MD, 21287 Robert E Hoes 32 Registrar's Signature 31. Date filed (Month, Day, Year) State park Registrar FEB 0 9 2010

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 1,3 per doc g900 2-8-10 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Bernard Katz 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL Sex 1 X M 2 □ F If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/22/1920 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Hours 89 Yrs. 034-07-3429 MA Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 1 ☐Yes 2 No MONTGOMERY SILVER SPRING 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 11013 BUCKNELL DRIVE 20902 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣 No Specify: Specify: 3 Midowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GRAPHIC ILLUSTRATOR CIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KRACOV ROSE KATZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 HYDE ROAD, SILVER SPRING, MD 20902 JACK KATZ / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/2010 ROSEDALE, MD SHAAREI ZION CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 1000 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death TORY SEPTIC SHOCK Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DISEASE RENAL 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Ye ar 5 Other (specify) ☐Yes 2☐No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DNFECTION TRACI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? NEUMONI 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 4 □ No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

**Physician** /Medical Examiner Examiner

**Physician** 

Examiner

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Evan inger out to motified at

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, if a Medic.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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and burial-t physiciar death certificate be the

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica

Physician/Medical

Completed by

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

27. Marner of Death

determined

FEB 0 8 201

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 ☐ Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature title of certifier

29d. Date signed (Month, Day, Year)

30. Name and liddress of person who completed cause of death (Item 23a) (Type, Print) WYEWINSL

31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

filled in by the

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 4b per doc g900 2-8-10 yt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			State Registrar		Certificate of D	eath	Reg. No. 2010 0333				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Kirk			late of Death Month Da	ay Year 3. Time of Death 3			
	Medic	al	Gertrude  4a. Facility Name (if not institution, give street as		4b. Сіty, <b>Раук, а</b>			2 2010 1820 M			
	Examin	er	9050 Iron Horse Lo		- Owing 1	Wills	"	Battomore			
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M 2	7. Age (In yrs. last	t birthday) If Under 1 Year Months Days	Hours Min. 8. D	ate of Birth Sonth, Day 1 Years 5 / 2 3 / 1 9 2 :	9. Birthplace (State or Foreign Country) PA			
	ind show at	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Town or Location			10d. Inside City Limits			
	Maryla 28a-f s atified	rect	MD BALTIMORE	PIK	KESVILLE			1 ☐ Yes 2 🗖 No			
	th the	al D	10e. Street and Number		10f. Zip Code		10g. Ci	itizen of What Country?			
	ath wil	Funeral Director	9050 IRON HORSE LAN  11. Marital Status 12. Wa	E, #108  Decedent Ever in U.S.	21208	spanic Origin? (Specity Yo	es or No-	USA 14. Race - American Indian,			
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1	led Forces? Yes 2 X No es, Give	If Yes, specity Cubar 1 ☐ Yes 2 🕅 No	n, Mexican, Puerto Rican	, etc.)	Black, White, etc.			
8	ours a' atural" cal Exa	Completed	3 X Widowed 4 Divorced Year  15. Decedent's Education	r or Dates.	16a. Decedent's Usual Occupa		100	Specify: WHITE			
215	n 72 h s. an "ns Medic	mple	(Specify only highest grade com	ege (1-4 or 5+)	(Give kind of work done d life. DO NOT use retired)		1 16b. r	Kind of Business Industry			
21	d withii ygiene her th	l oo l	12		HOMEMA			OWN HOME			
and	uld be filed Mental Hy narked oth	10 B	17. Father's Name (First, Middle, Last) HARRY	K	(ERMAN	18. Mother's Name (First ROSE	t, Middle, Maiden	den Surname) UNKNOWN			
aryl	should and Me is mari aumati		19a. Informant's Name/Relationship (Type, Prin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,						
Σ,	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		HARVEY KIRK/SON		10800 LINSO	N ROAD, OWII	NGS MILL	S, MD 21117			
Baltimore, Maryland 21215-0036	age 1 a nt of H to If ite / or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove	I from State LPB	ce of Disposition (Name of NEAD, Cyemapoly Prothe) Diac	Date	- 1	ocation - City or Town, State			
altin	permit. Page 1 Department of I Important: If it any injury or or		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	] SHA	AREÎ ZION CEM 22. Name and Addres			DALLSTOWN, MD & BROS., INC.			
<u>~</u>	permi Depar Impo any ir once.		Acott M. a	dth				VILLE, MD 21208			
ī.			23a. Part 1. Enter the disease, or complications shock, or heart fallure. List only one cause	on each line.		g, such as cardiac or resp	piratory arrest,	Approximate Interval Between Onset and Death			
	Priysician/ Medical		regulting in death)	Metastati ue to (or as a consequen		1 cance	r	2 years			
	Examiner		Se uentially list conditions b.	de to (or as a consequen	nce 61).						
	b it	nine	if any, leading to immediate cause. Enter Underlying	ue to (or as a consequen	nce of):						
	tificate be executed ng physician and s as the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	lue to (or as a consequen	nce of):						
00	e be e lysiciar le buri	Medical	d								
38760	rtificat ling ph e as th		IF FEMALE:	es, outcome of pregnance	24						
Box 6	attence attence I for us	Physician/	in the past 12 months?	Live Birth 2  Fetal d Pregnant at time of dea	death 3 🔲 Ectopic pregnanc	У		23d. Date of delivery  Month Day Year			
O. B	the deby the	hys	g □ Unknown g ∟	Unknown							
, P.O.	es that iigned be de	by	Part II. Other significant conditions contribution Pleural effyion	-	alnutrition			use contribute to the cause of death?  No 3 Probably 4 Unknown			
ords	been should	Completed by			0171001		24a. Was an	24b. Were autopsy findings available			
3ec	he law ite has	omb					autopsy performed? 1  Yes 2 X N	prior to completion of cause of death?  Io 1 ☐ Yes 2 ☐ No			
tal	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?			ace of Death (Check only		0 12 100 22 10			
Ę	Physi rthis c ral dire	2	1 L Yes 2 ANO	1 Inpatient 2 EF	R/Outpatient 3 DOA Other 8b. Time of 28c. Injury	4 ☐ Nursing Home 5	5 Residence ( Describe how inju				
ou c	ath. r: After	icate	1 🕅 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year)	injury work	Yes 2 No	Social New Injul	y occurred			
Division of Vital Records,	l or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		ocation (Street are Dity or Town, State	nd Number or Rural Route Number, e)			
Ω	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendicompleted filled in by the funeral director, page 2 should be detached for use	Medical			dge, death occured at the time,			nd manner as stated. e, and due to the cause(s) and manner stated.			
	o the l	Me	only one) 3 Certifying Nurse Pract	oner: To the best of my kr	knowledge, death occurred at the	time, date and place, and	due to the cause(	(s) and manner as stated.			
	->-0		D Roggen	MO	Da	35844	Fel	bruary 03 2010			
	10V		30. Name and address of person who complete	d cause of death (Item 23	3a) (Type, Print) Road Suite	108 Ru	indalist	bruary 03 2010  Dirk MD 21133			
	Sta Registra		31. Date filed (Montir, Dáy, Year) FEB 0 8 2010	32. Fegistrar s Signature	8. parl						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Beverly Delaune Lownie 10:10PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🏋 F Feb 4, 1940 Massachusetts 513-34-1249 69 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho Director 1 Yes 2 1 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 109 N. Union Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) City Government Storm Water Management permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other t. any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pauline Maloney Noel Joseph Delaune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 Honeysuckle Drive Bel Air, Maryland 21014 Jacqueline Burke, Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State cemetery, crematory or other place) Metro Crematory Inc.: 02/04/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Name and Address of Facility Of Maryland, Inc. 19 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of); Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): the attending physician and the for use as the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 10 √es 2 □ No 3 □ Probably 4 □ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျှ 1  $\square$  Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 14 Natural 2 Accident 5 Pendina Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying Nurse Fractioner To the best of my knowledge, death occurred at the time. Jake and place, and due to the cause(4) and marrier as stat. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammaa 10klodar, 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februar 2010 5:08 P M Doretha Allison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8860 Piney Branch Road, Montgomery Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 😿 F Days Hours Aug 24, Months North Carolina 90 Director 245-34-1731 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with. 8860 Piney Branch Road, 20903 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filk tment of Health and Mental i tant: If item 27 Is marked o marked ္ပဝ Alfred Allison Annie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry David Lyte/son 8860 Piney Branch Road, #503 Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any Injury or o once. 1 Burial 2 X Cremation 3 Removal from State 4 Dogation 5 Other (Specify) Final Journey Crematory 2/10/2010 Woodbine, Maryland 21. Signa re of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Momao Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, or complications that caused shock or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death
3 months Filysician/ Metastatic Ovarian Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the bunal Physician/Medical certificate be IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death detached 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Division Investigation 6 Could not be 1 ☐ Yes 2 ☐ No Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of V

To the Hospital or Attending Phys
within 24 hours after death.
To the Funeral Director: After this

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip W. Poth, M.D. 8712 Maywood Avenue Silver Spring, Maryland 20910

31. Date filed (Month, Day, Year)

FEB 0 9 2010

S2. Registrar's Signature

Authority

Authority

Phillip W. Poth, M.D. 8712 Maywood Avenue Silver Spring, Maryland 20910

4. Goth no

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

February 8, 2010

29c. License number

D22309

State

Registrar

only one)

29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2010

A factor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ple 9650 Sentrajo Ra Rute 110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 31-2010 AIHTUX DWRIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL UNION KTON Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. 4-10-211-52-581 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State Prof. Pust be notified at 1 Yes 2 □ No **Funeral Director** -LKTON MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5. USA NAVA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Specify: BL Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by other traumatic event, the Ne digni Evan 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be -DMOHDS 2 WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. MD 21921 TRAILY ELECTON NAVALO -OWRIE OSEPH 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FERNWOOD CEMEDER 2-6-2010 FERNWOOD, PA 19050 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Philadelphia, Haveford Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio pulmonas /Medical Due to (or as a consequence of): **Examiner** arrest prediac Sequentially list conditions, If any, leading to minimal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Box 68760, 1 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) <u>о</u> 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Þ the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2) No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

Registrar

29b. Signature and title of certifier

Mysiuan

Bow

Street

30. Name and address of person who is impleted cause of death (Item 23a) (Type, Print)

29c. License number

D69048

MD

Elkton

29d. Date signed (Month, Day, Year)

311

21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2:19 PM Physician/ Lovely Elaine Lewis 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Anne Baltimore Washington Medical Cent Glen Burnie Hrunde If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours (Month, Day, Year) av 5. 1943 Country) 214-38-4458 **Director** Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Maryland Glen Burnie 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 21060 219 Carroll Rd. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 X Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fed Ex Courrier permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Lovely Margaret Christina Hughes Jack Robinson Tishue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD Cindy Lee Lewis / Daughter 219 Carroll Rd. 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Glen Haven Mem. Park Feb. 5, 2010 Glen Burnie, Maryland re of Fun ral Ser Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy. SE; Glen Burnie, 21. Sign 21061 C 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions cause (Disease or iinjury that initiated events Due to for as a consequence of the attending physician and hed for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Month Year Pregnant at time of death r signed by the a 9 Unknown g 🗌 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by mounacula 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy perform performed? 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

Registrar DHMH 17 Rev 7/2009

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State

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)

(AVIRIA

MD

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29d, Date signed (Month, Day, Year)

21061

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Gordon Hall Livingston 9:10 A 2010 February 7. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Health Care Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours tXM 2□F 97 049-07-6933 Director Nov. 27, 1912 North Dakota Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Montgomery 1 ☐Yes 2X No MD Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Russell Ave. 20877 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1. □ Yes 2 □ No 1. Yes, Give Year or Dates 1941-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Livingston Elizabeth Hall Robert Hannah ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marion M. Livingston / Wife 401 Russell Ave., Gaithersburg, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 2/9/2010 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service Lice 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 12 reimers Wears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physlclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

within 24 hours after deatl To the Funeral Director: completely filled in by the 24

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

FEB 0 9 2010

helnich 32. Registrar's Signature 31. Date filed (Month, Day, Year) back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

M

1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Morebrua Pry 7, Y2=010 **Physician** Maria Elso Legg /Medical 4c. County of Death 4b. City, Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Manor Care Falls Koad **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Octoor Day, Year 32 9. Birthplace (State or Foreign Many Mand Social Security Number 219-28-9624 6. Sex 7. Age (In-yrg. last birthday) **Funeral** 1 □ M 2 🗸 F Yrs. Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County "natural", or Items 23a or 28a-f show coical Examiner must be notified at MD Anne Arundel Pasadena 1 ☐ Yes 2 No Direct 10g. Citizen of What Country? 10e. Street and Number United States 54 Maghothy Beach Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Miscreal Examinat must once. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black. White, etc. 1 □ Never Married 2 □ Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College 1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame)
Marie 17. Father's Name (First, Middle, Last)
Mathew Weber Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 242 Oleander Avenue Palm Beach, FL 33480 19a Informant's Name/Relationship (Type, Print) Colleen Mathews /Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Chesapeake Crematory Feb 09, 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22Cremationssando Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 hetter Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) ician/Medicai attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 2 No certificate 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) I Director: After to d in by the funera 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 2 🗆 No 1 Yes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Funeral 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

FEB 0 9 2010

29a. Certifier

29b. Signature and title of certifier

Narender 31. Date filed (Month, Day, Year)

Bhenas 8813 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

24

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2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	1 _ State	partment of Health and Ment ertificate of Death	0.0.						
			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. 2 3 Time of Death						
	Physicia Medic		Gloria Lawman	M	O2 O2 2010	01118 4					
بيعد	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat						
	i		Baltimore Washington Medical Center	Glen Burnie	Glen Burnie Anne Arundel						
	Funeral		5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthdi	Months Days Hours Min. (M	ate of Birth 9. Birth fonth, Day, Year) Co. D/18/1952 Mars	hplace (State or Foreign untry) / land					
Ļ	Director		216-60-5056		0/18/1952 [Mary	/land					
	and show	ī	10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits					
	Maryl 28a-f otifie	rec	MD Anne Arundel Glen B	rnie		1 🗓 Yes 2 □ No					
	a or a		10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	-					
	h with	Funeral Director	135 Faywood Court, Apt. L	21061	U.S.A	•					
	r deat or iter iner		Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,</li> </ol>	es or No- etc.) 14. Race - Ame Black, White						
036	s afte al", c Exam	q p	1	1 ☐ Yes 2 🛣 No Specify:	Specify: Wh:	ite					
2-0	hour natur dical	Completed by		cedent's Usual Occupation we kind of work done during most of working	16b. Kind of Business	Industry					
2	nin 72 Je. Han te e Me	E O	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)							
2	d with	(1)	6 L	undrist	Health C , Middle, Maiden Surname) Un						
ano	be file antal l ked o c eve	10E	Albert Lowman	16. Wother's Name (First,	, Middle, Maiden Surname) Ott	KIIOWII					
ary	nould nd Me s mar umati			ailing Address (Street and Number or Rural Route	e Number, City or Town, State, Zig	Code)					
Σ	and 2 st Health a tem 27 is		John Lowman / Son 18	O Ridgewick, Glen Bur	nie, MD 21061	,					
ore,	of He of He if item roth			position (Name of Date rematory or other place)	20c. Location - City or	Town, State					
Ĕ	Page ment tant: l			Gifts Registry 2/5/20							
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Leense-	22. Name and Address of Facility Anato							
	40 = 60		23a. Part 1. Enter the disease, or complications that caused the death. Do not	7522 Connelley Drive,							
	arana and		shock, or heart failure. List only one cause on each line.	1	natory arrest,	Approximate Interval Bet een Onset and eath					
<	Physician Medical		disease or condition resulting in death)	. tachy cardia		unites					
	Examiner		(Walso wy	execten		Clears					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence(of))								
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J.	te be executed nysician and ne burial-transi	al E	resulting in death) Last Due to (or as a consequence of):								
9	res that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit d	Physician/Medical Examiner	d								
Box 687	certific nding	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of del	iven					
XOX	eath c atter	icia	in the past 12 months?  1 ☐ Ves. 2 ✓ No.  1 ☐ Ves. 2 ✓ No.	B	Month	Day Year					
П	the d by the ached	hys	9 Unknown								
P.0.	s that gned I	þ	Part II. Other significant conditions contributing to death but not resulting in t	e underlying cause given in Part I.	3e. Did tobacco use contribute to	the cause of death?					
ds,	equire een sij ould t	ted			1 Yes 2 No 3 P	robably 4 🗹 Unknown					
Division of Vital Records,	faw re nas be s 2 sh	Completed	-	2	autopsy prior to o	topsy findings available completion of cause of					
æ	: The icate l			1	performed death?  Yes 2 No 1 Yes	2 No					
ital	siciar certif recto	Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1   Inpution: 2   FR/Output	26. Place of Death (Check only of Other:	_/						
₹ 	y Physer this eral d	e: 10	27. Manner of Death 28a, Date of injury 28b. Tim	of 28c. Injury at 28d. D	Residence 6 Other (Special Residence 6 Other Residence 6 Other (Special Residence 6 Other Residence 6	ify)					
uc	ath. r: Afte	icat	1 DN Natural 5 □ Pending (Month, Day, Year) inju 2 □ Accident Investigation	/ work? M 1 ☐ Yes 2 ☐ No							
/isi	r Atte ter de recto by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		ocation (Street and Number or Rui ity or Town, State)	al Route Number,					
á	oital o urs af ral Di										
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de: (Check 2 Medical Examiner: On the basis of examination and/or in	estigation, in my opinion, death occurred at the tim	ne, date and place, and due to the o	ause(s) and manner stated.					
	To the vithin To the comple	Σ	only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier	e, death occurred at the time, date and place, and	due to the cause(s) and manner as  29d. Date signed (Month						
	- 7 - 0		( Cutatolo	D34480	02/03/	2010					
	`		30. Name and address of person who completed cause of death (Item 23a) (Tyr	, Print)							
	1		Hyun Joseph Lim, MD 19	17 Wadian Park Dy	Glan Service, U	M)					
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature		ŧ						
	negistra	al .	FER A SAIN COMME LE LA								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** :40 2010 PD. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more ACV 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🕅 F 57 213-62-5518 Yrs. Director Oct 20, 1952 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, I'm Modical Evanding Trust to retified at 1 ☐ Yes 2√ No Director MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Enchanted Hills Road 21117 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Specify: ð 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event, In a man injury or other traumatic event. phlebotomist 12 healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Hammond Willey Mary Ann Crouch ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Lapier/spouse 110 Enchanted Hills Road Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sign ture | Funeral Struce Sicensee 3 State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 21201 23a. Part \ Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Ca we (Final disease or condition resulting in death) **Physician** 12ars 1010 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to for as a conse wence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 I Inknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 No 2 🗆 No 1 ∐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. determined 4 Homicide

Division

or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

> State Registrar

Medical

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mars

Elkridge, Md 21015 rive

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 11:58 P <sup>™</sup> January Dolly Freda Leese Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll 8. Date of Birth
(Month, Day, Year)
Dec. 9, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Maryland Dec. Director 215-32-9214 76 Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 Old New Windsor Rd. 21776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed White Ith and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill of Health and Mental item 27 is marked or မ Laura Stitely Guy Edward Baile 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2116 Bethel Rd. Finksburg. MD 21048 John C. Leese / husband item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 þ cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2/3/2010 4 ☐ Donation 5 ☐ Other (Specify) Winters Cemetery nr. New Windsor, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home garine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? ō Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perfor death? certificate 1 🔲 Yes 2 No Yes Division of Vital 25. Was case referred to medical or Attending Physician: director, 26. Place of Death (Check only one) æ examiner' Hospital 1 Tyes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Inpatient funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred the Funeral Director: After Inpleted filled in by the funeral injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2.

(Check

only one) 29b. Signature and title

30. Name and address of person who comple

ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00059552

POOLE RP WESTINGTER

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh g900 2-26-10 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Johnny C. Locklear \_P M February 2010 11:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehab Chestertown Kent 5. Social Security Number **Funeral** 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. Month, Day, Year, 11/18/57 Country) Maryland Director 218-<del>76</del>-5563 52 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Oueen Anne Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 635 Chester River Beach Rd. 21638 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Mental Hygiene. larked other than Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ္ Peter Locklear Zola Bonnett Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Gay Bennett Sister 635 Chester River Beach Rd. Grasonville, MD 21638 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/9/10 Baltimore, Maryland Baltimore Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home <u>3620 Wilkens Ave. Baltimore, Maryland 21229</u> 23a. Part 1. If ter the disease, shock, r heart failure. List omplications that cause he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, terval Between Immediate Cause (Final disease or condition set and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Dus to for sels consequence of if any, leading to infinediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inversid rector, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 5 Pending injury 2 🗌 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Legisland of the cause(s) and manner as stated.

Legisland of the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16 am Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2010 03346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 10:07 PM 2010 inveso /Medical 4c. Cou street and number) Town, or Location of Death (If not institution, give **Examiner** move STOW 9. Birthplace (State or Foreign Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Country 1 M 2 KF -129 Kansa 510 -Yrs 50 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f show the Medical Evention roust be notified at 1 ☐Yes 2 ☑ No sterstow A **Funeral Directon** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21136 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Back <u>م</u> 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life., DO NOT use retired) ulth and Mental Hygiene. 27 Is marked other than ' r traumatic event, the "hy Elementary/Secondary (0-12) College (1-4or 5+) Steward a 18. Mother's Name (First, Middle, Maiden Se 17. Father's Name (First, Middle, Last) ၉ sa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) alu of Health Department of Health Important: If item 27 any Injury or other tronge. Williams 27 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State land 4 ☐ Donation 5 ☐ Other (Specify) 2010 Kansas 21. Sign wre Funeral Service License Carl ullo 23a. Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician now /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation n 24 hours after death.

ne Funeral Director: Aft
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ted cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Old Court Road Randallstown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 3:48 p February James R. Logan Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Reisterstown 316 Leyton Road 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 | F Days Hours 215-42-9912 65 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 X No Baltimore Reisterstown MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Funeral items 23a U.S.A. 21136 316 Leyton Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Carroll Engineering Civil Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Alexander Gladys Manley other traumatic Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 316 Leyton Road Reisterstown, Maryland Barbara Ann Logan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/2010 Lutherville, Maryland Saters Baptist Cem 22. Name and Address of Facility 11824 Reisterstown Road of Funeral Service Licensee hon SOR 21136 Reisterstown, MD ELINE FUNERAL HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic ancreatic disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the bunal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 1 Yes 2 L 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending work' within 24 hours after Geau..

To the Funeral Director: After the function of t 1 Tes 2  $\square$  No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar DHMH 17 Rev 7/2009 only one)

6569

MD

St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4569 N. Charles St. Suite 205

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

006932

2010

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Christine Louise Morningstar February 8. 2010 8:16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3821 Graceland Court Howard Ellicott City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Min June 10 Year) Months Hours 231-07-7409 91 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2🏋 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3821 Graceland Court 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Completed 3 ¥ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker other traumatic event, Be permit. Page 1 and 2 should be filed Department of Heath and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isabella Henry Frank Gav Boltwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine L. Young, daughter 3821 Graceland Court Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory, Inc. 02/09/10 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Shortness disease or condition resulting in death) Medical Due to (or as a consequence Examiner WEEKS Pneumonia Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin YEARS ongestive Due to (or as a consequence of): resulting in death) Last physician a s the burial-Pulmonary Physician/Medical YEAR S IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death
Unknown Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 No certificate 1 🗌 Yes 2 🗆 No J Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 Pending thin 24 hours after death.

the Funeral Director: After impleted filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 | Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055810 February 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Jyothi Rao-Mahadevia, M.D.

Box 68760

P.O.

Records,

**Division of Vital** 

4801 Dorsey Hall Dr., Suite 201 Ellicott City, MD 21042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 100 AM - urman Mack 9 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 000 Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Date of Birth (Month, Day, Min 1 № M 2 🗆 F Months Days Hours 8 Yrs 51-40364 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.

ttem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examir or must be inclifted at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 000 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 100 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working (life). DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 000 MD 21215 permit. Pages 1 a Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter in: disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 □No 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? \_\_ Be 26. Place of Death (Check onl. ne) 1 ∏ Yes 2 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 24 the 29b. Signature and title of centile 29d. Date signed (Month, Day, Year) 0 29c. License number MKYapakse M.D 20057465

State Registrar

31. Date filed (Month, Day, Year) FEB 0 9 2010

Kajapakse, M.D

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D. 2835 Smith Av., Suite 203

Baltimore, MD. 2120 9.

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Amend #5, per Fh g901 3/5/10 TT  State of Maryland / Department of Health and Mental Hygiene													
		•	State Registrar					tificate				Reg. No	001	0	03350
	Physicia	ın/	1. Decedent's Nam		Last) Massie, Sr.						2. Date of D Month		Y 2 Ye	ear O (O	3. Time of Death A
)	Medic Examin				give street and number)			4b. City, To	wn, or	Location of Death		40	. County of D	Death	
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	Funeral Director		5. <b>2°18</b> Seguity 8	7353	1 🛭 M 2 □ F	74	ast birthday) Yrs.		Days	Hours Min.	8. Date of B	1.935	9.	Country	ce (State or Foreign laryland
	land show dat	to	Usual Residence o	10b. County		10c. Cit	y, Town or Loc				-	100	d. Inside City Limits		
	e Mary r 28a-1 notifie	Director	MD 10e. Street and Nu		ngton	<u> </u>	пая	gersto				1 Tyes 2 10g. Citizen of What Country?			1 Yes 2 No
	with the s 23a c	Funeral			Avenue				174	O		_	.S.A.	t Oodini,	y:
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  It health and Mental Hygiene. It without it is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	<ul><li>11. Marital Status</li><li>1 ☐ Never Marital</li><li>3 ☐ Widowed</li></ul>		12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	?		Vas Deceden f Yes, specify		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race - A Black, V Specify:		·
2-0	2 hours "natur edical l	Completed	(Spe		t's Education st grade completed)		16a. Deced	lent's Usual C	occupa Sone d	ation Turing most of wor	king	16b. k	16b. Kind of Business Industry		
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Maryland 21215-0036	ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name	(First, Middle, La Bruce Ma	· ·					18. Mother's Nar Virgin	ne (First, Middle ia Loui				
, Mar	nd 2 shoul ealth and I m 27 is m: ier trauma		19a. Informant's N John E	ame/Relationsh L. Massi			19b. Mailir 1572	ng Address (S 29 Hot	treet a	ane, Sha	ral Route Numb rpsburg	er, City or MD	r, City or Town, State, Zip Code) , MD 21782		
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Ardent Cremation Services 02/08/2010 Hanov											-	
Balti	permit. Page 1 Department of Important: If I any injury or once.		21. Signature Fu		-		22	. Name and A			rdent C				
			23a. Part 1. Enter	the disease, or	complications that cause nly one cause on each li	ed the deat	h. Do not ente						, Hanc	A	, MD 21076
	hysician/	4	Immediate Cause disease or condition	(Final		2010	onae	et c	U	ten	- d	びと	eare		nterval Between Onset and Death
	Medical Examiner		resulting in death)		Due to (or as	s a consequ	uence of):			1	)				
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*	e executed sian and urial-transit		Cause (Disease or that initiated event resulting in death)	ts	c. Due to (or as	s a consequ	uence of):							+	<u></u> .
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Division of Vital Records,	ottendii death. ctor Ai y the fu	Certificate:	2 Accident 3 Suicide	Investig 6   Could r	ation ot be	niury - At ho		M et factory o	1 🗆 '	Yes 2 No	28f. Location	(Street an	d Number or	Rural Ro	oute Number
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	To the vithing to the company of the		29b. Signature and	title of certifier				29c. Li	icense	number		29d. Da	te signed (Mo	onth, Da	
	$\circ$		30. Name and addr	ress of person. v	who completed cause of	death (Item	23a) (Type, P	rint)	), ()	66116	Λ	71-7	2   8   1		10
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 0843 WILLIAM MCKEWEN 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Good Samaritan Hospital Baltimore 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Maryland Hours 1 🛛 M 2 🗆 F Director 214-50-0662 63 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ld be filed within 72 hours after death with the Maryland Mental Hygiene. Director 1 X Yes 2 No Baltimore Essex MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral U.S.A. 21221 648 Middelsex Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White marked other than "natural", 3 Widowed 4 X Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housing Carpenter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Dorothy Jeanette Gorman McKewen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 648 Middlesex Rd, Essex, MD 21221 Janet Kahler / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/08/2010 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 C Other (Specify) 21. Signature of Funeral Service Liminsee 22. Name and Address of Facility Anatomy Gifts Registry P, Hanover, MD 21076 Connelley Dr., Ste. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to tor as a consequence on After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 4 Pregnant g Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 Ŀ 9 ☐ Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

completed filled in by the within 24 hours a To the Funeral C

> State Registrar

only one)

29b. Signature and title

31. Date filed (Month, Day, Year)

FEB 0.9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2543

Bulevard

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEbruary Physician/ Thomas M. Miles 2010 6:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Y Aug 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 ₹ M 2 □ F 1941 Director 207-30-2949 68 Pennsylvania Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Glen Burnie 1 ☐ Yes 2 √ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 2715 Robin Road 21060 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. white Specify than "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ real estate property manager other ould be filed w nd Mental Hyg marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hannah Mervine Thomas McGarvey should I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .s permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2715 Robin Road Glen Burnie, MD Diana L. Miles/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Sign fure I Funeral ervice Licen <sup>22</sup> Name and Address of Facility Board 655 W. Baltimore Street Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the burial Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to cleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown Division of Vital Records, 2 🗌 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to fical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital R/Outpatient 3 DOA ျပ 1 Inpatient 2 L 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗌 No Natural injury 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature ar 2 021684 ause of death (Item 23a) (Type, Print)
8021 RITCHIE HWY, DASADENA

Registrar

State

31. Date filed (Month, Day, Year)

FEB 09

10-00705 Arthur Myers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rthur Myers		- For State	ate of Maryla		artment of rtificate of		nd Mental		Reg. No. 20	10	03353	
Physiciar Medical Examin	1/	egistrar I. Decedent's Name (First, Midd Arthur	<sub>le,Last)</sub> Myers					2. Date of De Month January	ath Day Yea		Time of Death	
Medical Examini		la. Facility Name (if not institution	4	mber)		4b. City, Town, o	r Location of De		4c. County of			
	4	Anne Arundel Medica		7. Age (In yrs. I	ast hirthday)	Annapolis	ar If Under 24	Hrs 8 Date of F	Anne An		place (State or Foreign	
Funeral Director	İ	5. Social Security Number 232–50–4773	1 M 2 F	7. Age (III yis. II	Yrs	Months Day			.1935	Coun	try) WV	
ny	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion				1	0d. Inside City Limits	
ryland a-f show any	_	MD Anne	Arundel		C:	rownsvil	le.				1 Yes 2 No	
ne Maryla or 28a-f.	Director	10e. Street and Number 775 Old H	erald Han	rbor Ro	oad	10f. Zip Code 21 0	32		10g. Citizen of Wh	at Countr SA	y?	
	<b>-</b> L	11. Marital Status 1 Never Married 2 M	12. Was Dec Armed Fo	edent Ever in U prces?		as Decedent of H es, specify Cuba		( Specify Yes or Nerto Rican, etc.)	No- 14. Race White	e, etc.	in Indian, Black,	
after d	by F		vorced If Yes, Give Year or Dates:	r	1	Yes 2X N		of work dono	Specify:			
5 72 hours an "natur	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12)			during m	nt's Usual Occupa lost of working life Welder	e. DO NOT use	retired)	Cons			
-003 I within giene. ther tha	틹	12 17. Father's Name (First, Middle	. Last)			werder	18.Mother's N	ame (First, <b>M</b> iddle	, Maiden Surname)			
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Baltimore, permit. Pages l an Department of Hee Important: If ite	-	4 Donation 5 Other S	pecify:	F'11	22.	rney Cre	ss of Facility	2/8/2010	Woodb		MD	
Balt permit. Departi Import injury		21. Signature of Funeral Service Licensee Dorrota Marshall  22. Name and Address of Facility  Maryland Cremation Services  PO Box 1413 Baltimore MD 21203  23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
Physician Wedital		failure. List only one cause	on each line.				j, such as cardi	ac or respiratory a	irrest, shock, or he	ait	Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate tars after death.  "I Director: After this certificate has been signed by the attending physical in the funeral director, page 2 should be detached for use as the bu	žΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	the 1 Live b	ant at time of de	2 F	etal death 3 ther (Specify)	Ectopic pr	egnancy	23d. Date of Month	delivery Da	y Year	
by the a	ᇍ	Part II. Other significant condi	9OUKIN		resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contr	ibute to th	ne cause of death?	
F. P.C ires that signed	g D	Chronic obstructive	pulmonary disea	se, diabetes	s mellitus		<u>-</u>				bly 4 Unknown	
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n of ding Ph		27. Manner of Death	28a. Date (Month	of Injury n, Day,Year)	28b. Time of	,,,,, , , , , , , , , , , , , , , , ,	jury at Work? Yes 2 No		e how injury occurr	red		
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	2 Accident Inversion Suicide 6 Cou	estigation 28e. Plac	e of Injury - At h	nome, farm, stre	eet, factory, office				er or Rura	al Route Number, City	
Divis Hospital or A 24 hours after Funeral Directely filled in b		4 Homicide 29a. Certifier 4 Continue 5	ermined (Specify)  Physician: To the bes		dge death occu	urred at the time	date and place	and due to the ca	use(s) and manner	r as stated		
To the H within 24 To the F complete	Medical	one) 2 Medical Ex	aminer: On the basis and manners	of examination a	and/or investiga	ation, in my opinio	on, death occur	red at the time, da	te and place, and o	lue to the	cause(s)	
	Σ	29b. Signature and title of certif	ier // Ah				onse number		29d. Date sign January 25		п, рау, теаг)	
11		30. Name and address of person				Penn Street,	Raltimore	MD 21201				
St	ate	Melissa Brassell, MD 31. Date filed (Month, Day, Year	) 32. R	egi trar's Signa	ture		Daitimore,		<u> </u>			
Regist		FEB (	9 2010	Verenz	8.1	racket						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yvonne E. Meister 3:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Numbe 7. Age (In yrs. last birthday) 73 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-34-2081 Days (Month. 1 □ M 2 🔀 F Months Hours (Month, Day, Year 5/16/1936 Director Puerto Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Md Howard Woodstock 1 🗌 Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10801 Enfield Drive Unit 205 21163 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗷 No Black White etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist Dental Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Julio Valles pe 1 Gloria Pesquera permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie M. Stover(daughter) 2642 Wynfield Rd. West Friendship, Md. 21794. 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 02/04/2010 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville.Md. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.A. P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician en brovas cular Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Vear Pregnant at time of death signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy perform death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) xaminer? 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 2 XNo at home Pell Investigation 6 Could not be January 18,2019 unclear Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide R1 #205 home woodbuy M 10861 Entield within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) K149194 3,2010 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles 6701 N ND Towson

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 3 2010 Physician/ 06:45A M MORGENTHAU MANFRED Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner BALTIMORE ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS Social Security Number 7. Age (In vrs. last birthdav If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Funeral Country) GERMANY 1 🗶 M 2 🗆 F Days Hours ₩37*07/*1919 90 Yrs. Director 153-18-3772 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland items 23a or 28a-f shorer must be notified at Director 1 Yes 2 No OWINGS MILLS MD BALTIMORE 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral USA 4730 ATRIUM COURT, #368 21117 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) CHEMICAL ENGINEER UNITED STATES GOVERNMEN ulth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ MORGENTHAU FRIEDA MARUM MAYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 5480 HUNTING HORN DRIVE, ELLICOTT CITY, MD 21043 PAUL MORGENTHAU / other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State <u>+</u> 5 Department o Important: If any injury or 2/5/2010 OHEB SHALOM MEM. PARK REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Toca 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy □ Live Birth 2 □ Fetal deat □ Pregnant at time of death □ Unknown in the past 12 months? Month Day Year 2 No ate has been signed by the page 2 should be detached g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 1 🗆 Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) Assisted Living 1 🗆 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending s after death.

I Director: Aff
d in by the fur 1 Yes 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

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Lavanya

31. Date filed (Month, Day, Year

2401

Registrar's Signa

W. Belvedere Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

orlagadda, MD

02-03-2010

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Patricia 2010 Pennacchia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frankling School G. Sex Age (In yrs. la Iti mose 505 B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🔀 F 213-34-8651 Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Rosedale Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21237 Funeral 4816 Brightleaf Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DeNitti's Rest. Waitress 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Speranzella Margaret Winks ပ permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is mark any injury or other traumationce. 19a. Informant's Name/Relationship (Type. Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony H. Pennacchia 4816 Brightleaf Court Rosedale, Md. 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 2-9-2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph N. Zannino Jr. F.H. 263 S. Conkling St. Balto. Md. 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of) Examiner cell Mall Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physiclan; The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate har rector, page 2 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Funeral C hours Certifying Physician: To the best of my knowledge, death occurred the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D89193 FEBRUARY, 4,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 FRANKLT SQUARE DRIVE JOHN KOTTARATH 20 M.1 BACTIMORE 31. Date filed (Month, Day, Year) FEB 0 9 201

Registrar DHMH 17 Rev 1/2001

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32: Registrar's Synature

		-	State of Maryland / Dep  1 - State Registrar Ce	artment of Health <i>rtificate of Death</i>		ıtal Hygier Reg. ı	0010	03357	
Phy	/sicia	n	1. Decedent's Name (First, Middle, Last) Howard E. Phillips, Sr.		2. [	Date of Death	L 0 . 0	3. Time of Death	
/M	ledic amin	al .	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		4	5, 2010 4c. County of Death	8:10 p.mM	
<u>.</u>	a sheet has		15916 Dark Hollow Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Upperco If Under 1 Year If Under	er 24 Hrs.   8, [	Data of Dinth	Baltimore	-1	
Fune Direc	_		219–34–0479 <sup>1</sup> X M 2□ F 71 Yrs.	Months Days Hours	s Min.	Month, Day, Yea	1938 Mary	nace (State of Poreign http) Land	
yland	at	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits	
the Mar 28a-fsh	otified	ector	Maryland Baltimore County Upperco	10f. Zip Code		100	Citizen of What Cou	1 □ Yes 2X No	
th with	ist be n	al Dir	15916 Dark Hollow Road	21155			ted State		
Iryland 21215-UU36 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "ratural", or items 23a or 28a-f show	examiner mi	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Clif Yes, specify Cuban, Mexic  1 Yes No Specify		Yes or No- in, etc.)	14. Race - Americ Black, White, Specify: Wh		
15-0036 n 72 hours af "natural", or	edical	leted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during mo DO NOT use retired)	ost of working		16b. Kind of Business/Industry		
d Z1Z15 filed within 72 Hygiene.	t, the M	Completed	Elementa P/Secondary (0-12) College (1-4or 5+) pro	ject manager			nstructio	n 	
Yiand rould be file Mental Hy narked oth	ic even	To Be	17. Father's Name (First, Middle, Last) William R. Phillips		elyn Gra	rst, Middle, Maid AMMEr	en Surname)		
Ma nd 2 s allth ar 27 is	other traumatic		Regina Shaffer Phillips - wife 1591		Road (	Jpperco,	Maryland	21155	
<b>Baltimore,</b> permit. Pages 1 as Department of Hee Important: If item			4 Donation 5 Other (Specify) Carroll	osition (Name of ematory or other place) Cremation	Feb. 9 2010	П	Location - City or To	,	
Departiment Impor	any In		21. Signature of Funeral Service Lieensee  M00741	2. Name and Address of Fac 934 South Mair	<sup>allity</sup> Eline n Street	e Funera Hamps	I Home stead, Mar	yland 21074	
8.			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such a	as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death	
Physic /Medi	cal		disease or condition resulting in death)  a	raer			3	month 5	
Exami		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
ecuted	-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
cate be executed physician and	e buria	dical	d.						
<b>SOX 68</b> eath certifica attending ph	se as th	/Medi	IF FEMALE: 23c. If yes, outcome pf pregnancy				Ond Date of deliv		
ج ۽ ج	tached for u	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	Day Year	
	pe	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Parl	rt I.	23e. Did tobacc	co use contribute to to 2 No 3 Pro	the cause of death? bably 4 Unknown	
Hecords, he law requires to has been signed	ge 2 sho	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of	
	director, pa	Be Co	25. Was case referred to medical examiner?	26. Pla	ace of Death (CI	1□ Yes 2□		2 □ No	
P F E	ਰ ਹ	၉	1			5 Residence	e 6 □Other (Speci	fy)	
LIVISION I or Attending after death. Director: After	the tune	cation	Month, Day Year) Injury  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be  288 Place of injury At home form s	M 1 ☐ Yes 2 [					
DIVI	ed in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f.	Location (Street City or Town, St	and Number or Rur ate)	al Route Number,	
UIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director, After	completely filled in by	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal one in the basis of examination and/or and manner stated.	th occurred at the time, date nvestigation, in my opinion, d	and place, and death occurred a	due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To the within 2	Eoo	M	29b. Signature and title of certifier	29c. License number	25	29d.	Date signed (Month) $2/9/20$	Day, Year)	
Ì	Q		30. Name and address of person who completed cause of death (Item 23a) (Type CP(9N) WD 6005 /V)	Clarles SS	T, BA	LMERQ	MD 2	1204	
Re	Sta gistra		31. Date FEB 0 9 2010 Server S. January S. January S. January		′		/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 4:07 PM Januar Dawn Price 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore 5. Social Security Numberunk If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk 6. Sex 8. Date of Birth 7. Age (In vrs. last birthday) Funera Months Days Hours Aug 27, Year)948 1 □ M 2 🗓 F 61 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5009 Frankford Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation unk 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Memorial Hospital 201 E. University Pkwy Baltimore, MD permit. Page 1 and 2 Department of Health Important; If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖾 Other (Specify) in state Signature I neral S rvice Licensee State Anatomy Board 655 W. Baltimore Street Director 21201 Raltimore, MD Part 1. Enter the disease or commitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Immediate Cause (Final disease or contition resulting in dea Onset and Death Pnysician/ a ay ( mins. Medical Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has I autopsy death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🔀 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1. Natural injury 5 Pending To the moore after death.

Within 24 hours after death.

To the Funeral Director; Aft 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 🗯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D61966

State Registrar

DHMH 17 Rev 7/2009

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32 Registrar's Signature

Eric Paul

31. Date filed (Month, Day, Year)

10-00915 Ronald Lee Pletzer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

riala Esa		- For State Certificate of Death Reg. No.											
Physician		gistrar Decedent's Name (First, Middle	,Last)						Date of De Month	Dav	Year		e of Death
al Examine		Ronald L. Pletz						] F	ebruary	1, 20	10	114	42 hrs
di Examini		a. Facility Name (if not institution			41	b. City, Town, o	Location of	Death		- 1	c. County of		
	-4.	7689 Baltimore Annapo				Glen Burni		Anne A					
	٩.			n yrs. last bi	rthday)	If Under 1 Yes	ar If Under	24Hrs. 8	B. Date of B	irth(MM	I/DD/YYYY)	9. Birthplace	(State or
Funeral		Goodan Goodan,				Months Day		Min.	Jan.	17	1965	Foreign Country)	MD
Director	1	215-74-2545	1 M 2 F 4	)	Yrs.				Jan.	- ' '	1303		
	Ū	sual Residence of Decedent			l eti							10d. l	nside City Limits
any	1	Da. State 10b. County	10	c. City, Tow								1 [	Yes 2 XNo
P & 3		MD Anne	Arundel		Glen	Burnie							
Maryland 28a-f show any d at once.	읽	De. Street and Number				10f. Zip Code				10g. Ci	at Country?		
th the Maryland  23a or 28a-f sho notified at once.		7689 Balto. An	napolis Blvd.	Apt.	2	210	060				US	)A	
th the		1. Marital Status	12. Was Decedent Ev		12 1/29	s Decedent of H	ispanic Orig	jin? ( Spec	ify Yes or I	lo-		- American Inc	dian, Black,
ems t be	ו פֿ	Marital Status     Never Married 2 Ma	Armed Forces?	_	If Ye	es, specify Cuba	an, Mexican,	Puerto Ri	ican, etc.)		White		_
deal deal	?		1 Yes 2 2 orced If Yes, Give Year	No	1	Yes 2 X N	o specify:				Specify:	wh	nite
after	ᇗᆫ	Widowed 4 Diversity Divers	or Dates:	eted) I 16s		t's Usual Occup		kind of wo	rk done	16b	. Kind of Bus	siness/Industr	у
natu xam	completed		College (1-4 or 5+		during me	ost of working li	e. DO NOT	use retired	d)				
6 721 cal 1	[	Elementary/Secondary (0-12)	- '	' i i	Floral	Desig	ner			F	Florist	t	
orthin arthur	ĔĹ	12	n/a		1 101 41		18 Mother	's Name (F	First. Middle	. Maide	en Surname)		
Fled w	91	7. Father's Name (First, Middle,							erry	11.37			3
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Ronald F.				Address (Str	- Ju	nhor or Pu	ral Poute N	lumber	City or Tow	n. State, Zip C	code)
MD 21215-0036  2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene.  27 is marked other than "natural", or items 23a or 28a-f she unative event, the Medical Examiner must be notified at once	₽ſ	ga. Informant's Name/Relations	hip (Type, Print)										
MD nd 2 sho alth and m 27 is		John & Julia F	Pahl/parents			Dawson			Date	111 <b>e</b> ,	c Location -	City or Town,	State
and and Healt tealt tran	- 11	20a. Method of Disposition		1	e of Dispos natory or otl	sition (Name of other place)	cemetery,	1	Date	120	o. Loodiioii	on,	
Ore ges 1 t of 1 : If is		_	n 3 Removal from State	9		Cremato	)rv	2/3	3/10	-   -	Glen	Burnie	, MD
Limen trant	-	4 Donation 5 Other Start Signature of Puberal Priving			100.1	I A Adalas	on of Encilit	74					
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	-1	Michael Name of Punaral (vi) Michael Name (23a. 1 a T. Enter the Isaase or	Licerisce		10 4.5	emmon	Funer	ај Но	ome_o	f Di	ulaney	\_Valle	y, Inc.
	4	Mychael J. Na	gte	ne death Do	not enter t	he mode of dvir	ng, such as c	cardiac or	respiratory	arrest,	shock or ha	The Title	r imate Interval
Physician	- 1	failure. List only one cause										Be	Death
/Medical Examiner	- 1	Immediate Cause (Final disease	a. Hypertensive Ath	erosclero	otic Card	iovascular L	Disease						
LAMIIIICI	1	or condition resulting in death)	Due to (or as a consec	quence of):									
	. 1	Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	quence or):									
	힐	(Disease or injury that initiated	c.  Due to (or as a conse	quence of):									
pa tisu	۱ä	events resulting in death) Last	d.										
Records, P.O. Box 68760,  The law requires that the death certificate be executed teate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ᇙ	- INDENDED	AMENDED										
be exician	edical	UNPENDED									23d. Date o	f delivery	
760, cate be physic the burn	ΣΙ.	IF FEMALE: 23b. Was decedent pregnant in t	the 23c. If yes, outcom	e of pregnar		etal death	3 Ectop	ic pregnar	ncy		Month	Day	Year
68 ertifi iding	Ē	past 12 months?	Pregnant at	ime of death	- =	other (Specify)				- 1			
Box 687 e death certific the attending p	Sic	1 Yes 2 No 9 Ur	nknown 9 Unknown		2 0	Julei (Speen)							
he de f	Physician	Part II. Other significant condi	itions contributing to death	but not resu	ulting in the	underlying cau	se given in F	Part I.					ause of death?
that the detack by	by	raitii. Othor organicani	•						1	Yes :	2 No 3	Probably	4 V Unknown
cords, P.O. B law requires that the de has been signed by the 2 should be detached									24a. V	Vas an	24b.	Were autops	y findings available
reque pondie	Completed									utopsy erform <u>e</u>	nd2	prior to comp death?	letion of cause of
CO law law e 2 s	ם										No	1 🗸 Yes	2 No
Re The ficat	ပိ	25. Was case referred to medic	201			26.P	lace of Deat	h (Check	only one)				
certi	Be	examiner?	Hospital: 1 Inpatie	nt 2 E	R/Outpatie	nt 3 DOA	Other <sub>4</sub>	Nursin	g Home 5	Re	sidence 6	✓ Other: Sce	ene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the fact death.  The Director: After this certificate has been signed by the funeral director, page 2 should be detach.	ပ္	1 Yes 2 No	28a. Date of Inju		8b. Time o		Injury at Wo	ork?	28d. Desc	ribe hov	v injury occu	rred	
Of ing P After uner		27. Manner of Death  1 ✓ Natural 5 Pe	(Month, Day,Y				Yes 2	No					
fon tendi eath.	atic		nding restigation						28f Locat	ion (Stre	eet and Num	ber or Rural F	Route Number, City
/iSi r At ter d in ect in by	Ę		ould not be 28e. Place of In	jury - At hon	ne, farm, str	reet, factory, on	ice building,	etc.	or To	wn, Stat	te)		
Divital o	Certification:	4 Homicide (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ca											
losp 4 hou une		0 ::::	Physician: To the best of m	y knowledge	e, death occ	curred at the tim	e, date and	place, and	due to the	cause(s	s) and mann	er as stated.	ause(s)
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The Prother Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Ex	Physician: To the best of m xaminer: On the basis of exa and manner stated	mination and	d/or investig	gation, in my op	inion, death	occurred a	at the time,	uate an	id place, and	1 000 10 110 01	
To To Com	leo	29b. Signature and title of certi	and mariner stated				cense numb			2	29d, Date sig	gned (Month,	Day, Year)
	_	1 ACAR 1	1/1/222			C	.C.M.E.				February	2, 2010	
	1	Yamell Tout	rall, IVID)										
21		30. Name and address of pers		death (Item 2	23a)	111 Penn Si	reet Ralt	imore I	MD 2120	1			
		Pamela E. Southall,					icel, Dall	innote, I					
S	tate	31. Date filed (Month, Day Yea	Registra	ar's Signatur	e /2/1	Mal							
	tra	■ ►FRIIU	1 /UIU Kenin	w ps.	17								

10-00813	
Adeline Quillan	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

deline Quillan		1- For State Registrar	Sta	te of Maryland		artment of rtificate of		ia ivierii	ai Hygiene	Reg.	20		0336
Physician/ ledical Examine		1. Decedent's Nam							2. Date of Month	Death		ar	3. Time of Death 1107 hrs
ledical Exami	iner	Adeline Quillan  Adeline Quillan  4a. Facility Name (if not institution, give street and number)  Adeline Quillan  4b. City, Town, or Location of Death  4c. County of Death								of Death	1107 HIS		
		Mercy Hosp	oital				Baltimore						
Funeral Director		5. Social Security N				ast birthday)	If Under 1 Ye Months Da		Min.	,		Foreign	
Birector		1 M 2 XF 52 Yrs. June 6, 1957 Commaryland											Maryland
v any		10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor	MD 10e. Street and Nu	Baltimore unk 10f. Zip Code unk				140-	Citizen of W	-1.0	1 Yes 2 No			
he Mar or 28a	10e. Street and Number unk 10f. Zip Code							unk	109.	USA	iat Court	uyr	
Baltimore, MD 21215-0036 Departie. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Stall and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	eral l	11. Marital Status	S. 13. Was Decedent of Hispanic Origin? (Specifing Yes, specify Cuban, Mexican, Puerto Rica							an Indian, Black,			
er death	Funeral	1 Never Marri	-55	ied Armed Forces?  1 Yes 2  ced If Yes, Give Year		1 Yes 2 v No specify:				Specify: White			
urs afte tural" amine	þ	3 Widowed  15. Decedent's Ed		or Dates: y only highest grade com	pleted)	16a. Decedent	's Usual Occupa	ation (Give k	ind of work done	16	Sb. Kind of Bu		
6 n 72 ho an "na cal Ex	Completed	Elementary/Seco		College (1-4 or 5		during mo	st of working life		use retired)		77		
-003 d withii rgiene. ther th	omo	17. Father's Name	10 (First, Middle, La	ast) (	)		stock		Name (First, Mic	ldle, Mai		Mart	
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medisa	Be												
D 21 should and Me 7 is ma	욘	19a. Informant's Na							oer or Rural Rout e Laurel				
e, M and 2 Health item 2		Lydia B	position			Place of Disposi	tion (Name of ce		Date		Oc. Location -		
MOr Pages tent of int: If			_	3 Removal from Sta Sify: in state	ite (	crematory or oth	er place)						
Baltimore, permit. Pages I and Department of Heal Important: If iten		21. Signatur of Funeral Strice Licens 22, Nirector State Anatomy Board 655 W. Baltimore Street											
Physician	1	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval											
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a.  Between Onset and Death  Death											
zxammer		or condition resulting in death)  Due to (or as a consequence of):											
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause											
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kecuted n and - transit		d.											
68760, certificate be executed nding physician and	Medical	X UNPENDED		AMENDED 23a 23c. If yes, outcom	a, 27,	28a-f,p	ermE, g	900 2	/24/10 T	Γ	23d Date of	delivery	
Sox 6876 leath certificat e attending phy for use as the		23b. Was decedent past 12 months	pregnant in the	1 Live birth		2 Fet	al death 3	Ectopic	pregnancy		Month	Da	y Year
Box e death c the atten ed for us	ysic	1 Yes 2 🗸 I	lo 9 🔲 Unkno		ume or de	atri 5 Oth	er (Specify)			- }			
그 를 잘할	by Phy	Part II. Other signi	ficant condition	ns contributing to death	but not re	esulting in the u	nderlying cause	given in Par		_		_	ne cause of death?
										Vas an			ably 4 ✓ Unknown  opsy findings available
of Vital Records, ag Physician: The law requir Wher this certificate has been s	ompleted									autopsy perform <u>e</u>	d? d	rior to co	mpletion of cause of
tal Recian: The	ပ	25. Was case refer	red to medical	1	_		26.Plac	e of Death (	Check only one)	res 2	No 1	<b>✓</b> Yes	2 No
Vita hysicia this ce	To Be	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other Nursing Home 5 Residence 6 Other.											
n of iding P h After e funer		27. Manner of Death  28a. Date of Injury (Month, Day, Year)  1 Natural 5 Pending T1 1 (20 / 10 T1 10 20 T1 1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1 10 20 T1 10 T1										f	
Division tal or Attendi ts after death al Director: A	ficat	2   Accident   Investigation   F.d. 1/28/10   F.d. 10:0 am											
Divi ospital or , hours after uneral Diri y filled in	Certification:	Suicide    Suicide   Gould not be determined   Specify  Shower arear of dorm   Sheet, factory, office building, etc.											ger st
Ho Fur tely	Medical (	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)											d. cause(s)
To the within To the comple	Med	29b. Signature and		and manner stated.			29c. Licen				9d. Date signe		
		January 2								anuary 29	, 2010		
_		30 Name and addr Theodore M		7.7			111 Penn St	treet Rait	imore, MD 2	201			
S	ate	31. Date filed (Mont	-		's Signatu	re #		Dan		-01			
Regis			0.000	10 15	a	back							

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 0336 Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dexter Edward Robinson Feb 2010 6 3:45A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay, 10-11-5. Social Security Number Sex 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Min. 184-14-5326 Months Days Hours 86 Massachussetts Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 □ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1214 Woods Rd 21158 USA Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. College (1-4or 5+) Corporate Elementary/Secondary (0-12) Publisher 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any Injury or other traumatic event 17. Father's Name (First, Middle, Last)
Edward George Robinson 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Esther White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott E. Robinson-son 1214 Woods Rd., Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-8-2010| Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licens Homos 254 E. Main St., Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metadiate Clonyosarcoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed2 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Funeral Director: mpletely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State

DHMH 17 Rev 1/2001

Registrar

Norman Goldsein

31. Date filed (Month, Day,

Year)

rson who completed cause of death (Item 28a) (Type, Print)

32. Registrar's Si

25 Washin

03362

			For State Registrar	State of Maryl	-	artment of F rtificate of .			ene g. No.	
			Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death
	Physici /Medic		LEE G	ROSE	NBAUM			February	Day Year 2010	9:00 A M
	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death	1	4c. County of Death	
-re	4		Greater Baltimore  5. Social Security Number 6. S		nter vrs. last birthday)	Towson If Under 1 Year	If Under 24 Hrs.	10.00th (B)	Baltimore	
	Funeral Director		216-01-3153	□ M 2 💢 F	95 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 11/08/19	9. Birth Cou	place (State or Foreign intry) MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	ţō	MD N/A		BALTIMOR					1∭XYes 2 □ No
	r 28a	Director	10e. Street and Number		DALITHUN	10f. Zip Code	-	10	g. Citizen of What Cou	ntry?
	th with	al D	7121 PARK HEIGH	TS AVENUE, #	606	21215				USA
20	filed within 72 hours after death with the Maryland Hyglene. Hyglene are are a seen seen seen seen seen seen seen s	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	U.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	ican Indian,
5-0036	tural"	ed by	3 X Widowed 4 Divorced	Year or Dates:		dent's Usual Occup		16	Specify: WH	ITE
212	be filed within 72 hc tral Hygiene. d other than "natui event, the Medical	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	I (Give	kind of work done of NOT use retired	durina most of worl	king	JD. Killa of Dasilless/II	idustry
7	al Hygier other th vent, the		12			_SECRETA			LAW OFFIC	CE
yland	buld be fil Mental H arked otl atic ever	o Be	17. Father's Name (First, Middle, Last) BENJAMIN		GEARTN	FD	18. Mother's Nam	ne (First, Middle, Ma	,	EINER
	pus E E	To	19a. Informant's Name/Relationship (	ype. Print)				ral Route Number, (	City or Town, State, Zi	
, Ma	and 2 ealth a n 27 is		STEPHEN ROSENBA	JM / SON					.E, MD 2120	· · · · · · · · · · · · · · · · · · ·
ore,	les 1 a		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Romoval from State		sition (Name of natory or other place			Oc. Location - City or To	
Бапптог	Pages tment of tant: If ite jury or o		4 □ Donation 5 □ Other (Specify	nemoval nom state	BETH JA	COB CONG	. 2/5		FINKSBURG,	MD
מ	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licen	500					N & BROS.,	
			23a. Part 1. Enter the disease, or comp	lications that caused the d					ESVILLE, M	ID 21208 Approximate
	Physician		Snock, or neart failure. List only of Immediate Cause (Final	one cause on each line.	1	or the mode of dyn	g, such as calcino	or respiratory arres	,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or a a cons	sequence of):					/ week
	Examiner	<u>.</u>	Sequentially list conditions,	b						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of);					
ń	execunand ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):		<del></del>			
0/00	tificate be executed g physician and as the burial-transit	edical		d						
			IF FEMALE:							
5	rospira or Attending Prystolan; The law requires that the death certific bounds after death.  Funeral Director: After this certificate has been signed by the attending p tely filled in by the funeral director, page 2 should be detached for use as t	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3 🗆	Ectopic pregnancy Other (specify)	/		23d. Date of deliv Month	ery Day Year
	that the ed by detacl		Part II. Other significant conditions of	entributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
20.0	quires en sign uld be	ed by	acute heart	attack				Yes	2 ☐ No 3 ☐ Prol	bably 4 ☐ Unknown
נ	law re as be 2 sho	Completed	Costic Sten	osis				24a. Was an autopsy	24b. Were auto	opsy findings available
ב ק	i; The icate h ; page	Con	Severe Chion	ic obstui	dui	suhon	ery disi	performe	d? death? 1 ☐ Yes	·
-	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:	-	Othe	er.	h (Check only one)		
5 2	Physer this eral di	5	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	☐ ER/Outpatient 28b. Time of	3 LI DOA	4 □ Nursing Ho	ome 5 Residence 28d. Describe how	ce 6 Other (Special	fy)
5	ath. r: Afte e fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year		28c. Injury Work M 1 🗆	? Yes 2 □ No	Zod. Describe now	injury occurred	
	al or Atte s after deg al Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et a <i>nd Number or Rura</i> State)	al Route Number,
	ple ple	edical	29a. Certifier 1 ☐ Certifying Phyone) 2 ☐ Medical Example	rsician: To the best of my liner: On the basis of exame and manner stated.	knowledge, death ination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occur	, and due to the cau red at the time, date	ise(s) and manner as seand place, and due to	stated. o the cause(s)
Š	Zom within	Ž	29b. Signature and title of certifier			29c. License	number	290	l. Date signed (Month,	Day, Year)
				ethan			20907		14/10	
	5 V		30. Name and address of person who c	//	tem 23a) (Type, F	,	1. CL		1, 1	21204
	Stat	е	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	v Cha	us st,	Tows	on, maj	21009
	Registra		FFR 0.8 201	n /s \	1 1	0.0				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2010 Aldo Sansalone 7:12 P D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House <u>Rockville</u> Montgomery Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Hours Min March 20 Washington, Director 579-20-6838 85 1924 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho unty or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3164 Adderley Court 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Director of Admin Services Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Sansalone Rosina Errigo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Ann Sansalone/daughter Windsor Avenue Alexandria, Virginia 22301 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or c 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department Final Journey Crematory 2/9/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M thomas M00957 Manuta 21029 MD23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Lymphoblastic Leukemia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No detached 9 Unknown 9 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 **X** No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **N**0 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury XNatural 5  $\square$  Pending 1 Yes 2 No death Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 February 7, 2010

State Registrar 31. Date filed (Month, Day, FEB 0 9

Rockville, Maryland 20855

30. Name and address of persol/who completed cause of death (Item 23a) (Type, Print)
Bindu Joseph 6001 Muncaster Mill Road

32. Registrar's

Elsie E. Snyder    Feb	0 03364	lental Hygiene	Health and Mental Death	artment of F		State of Ma		For State Registrar			
Stammon   Stam	Year 3. Time of Death 4:10 P M	Month Day Ye	Mont	·		,					
Second Security Number   6 Sec   1 M SQ F   7 Apr (firty in sector chindry)   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   10 My   10 Mortins   1		4c. County of E	or Location of Death								
Source of the control	9. Birthplace (State or Foreign Country) Maryland	8. Date of Birth 9. (Month, Day, Year) 7 M	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year		Sex 7. Age	6.5 634	5. Social Security Num 213-05-1			
Elementary-Secondary (0-12)   College (1-4or 5+)   Mile, DO NOT use retained   Shoe Cutter   Clothing   Shoe Cutter   Shoe Cutter   Shoe Cutter   Clothing   Shoe Cutter	10d. Inside City Limits 1 ☐ Yes 2 💆 No		minster		10c. City, Town or Lo	11	10b. County	10a. State 1	'n	show ed at	
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Elementary-Secondary (0-12)   College (1-4or 5+)   Mile, DO NOT use retained   Shoe Cutter   Clothing   Shoe Cutter   Shoe Cutter   Shoe Cutter   Clothing   Shoe Cutter	- American Indian, , White, etc.	ecify Yes or No- 14. Race - A Rican, etc.) Black, V			Ever in U.S. 13.	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give		1 Never Married	þ	al", or items 23 Evaminer mus	036
17. Father's Name (First, Modile, Last)   18. Mother's Name (First, Modile, Master)   18. Mother's Name (Fir	· 1	ng	during most of working ed)	kind of work done of DO NOT use retired	(Give			Elementary/Second	ompleted	lene. than "natur he Medical	_
A   Donation 5   Other (Specify)   22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD   25.4 E. Mai	)		I		nes			17. Father's Name (Fi	Be	Aental Hygi rked other tic event,	64
A   Donation 5   Other (Specify)   22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD   25.4 E. Mai							•			alth and N 27 Is ma er trauma	Ž
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live.  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live.  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live.  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live.  25b. Medical Examiner  25c. Was deceded the pregnant in the past 12 months? In the p	rg,MD	2-10 Finksbur	cial 2-12-10	matory or other place on Memor	Evergree		Cremation 3 E	1 🖾 Burial 2 🗆		E E E	more
Physician / Medical Examiner  Sequentially list conditions, if any, leading to immediate Cause (Final disease or conditions) if any, leading to immediate Cause. Enter Underlying cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death) Last  Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying the sulfing in death Last Cause. Enter Underlying the Sequence of):  C. Chromatic Manuary During the Sequence of):  C. Chromatic Manuary During the Sequence of Sequence o					25	fletch	eral Service Lice	21. Signature of Fune		Depart Import any in	Balt
The state of the s	Approximate Interval Between Onset and Death 30 4715					aa.	failure. List only inal	shock, or heart Immediate Cause (Fi disease or condition resulting in death)		Medical	
The state of the s	5ys	,	Cisinse	dney L	a consequence of):	c. Due to ( r as a	litions, lediate ving jury	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Las	xaminer	and Il-transit	
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury at Work?  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred	Hys	L .	Fuline	finit.	estrie 1	d. Conge	l		dical	physician the buris	9289
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury at Work?  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred	· ·		су		2 Fetal death 3	1 ☐ Live birth 4 ☐ Pregnant at	onths?	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 🔀 1	ysician/Me	/ the attending ched for use as	O. Box (
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury at Work?  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred	bute to the cause of death?  B Probably 4 Unknown	A. at	ven in Part I. 23e.	inderlying cause giv	out not resulting in the u	contributing to death bu	ant conditions	Part II. Other significa	5	en signed by uld be detad	rds, P.
25. Was case referred to medical examiner?  1		autopsy prio performed? deat							Complete		
28d. Describe how injury occurred longer of longer	r (Specify)		ber:	nt 3 DOA Oth	ent 2 ☐ ER/Outpatie	Hospital: 1 ☐ Inpatie		examiner?	Be	is certific director,	f Vita
	d	28d. Describe how injury occurred  28f. Location (Street and Number of	ury at rk? 28d. Des rk? ]Yes 2 □ No	M 1 🗆	ny, Year) Injury	(Month, Day	investigation	1 Matural 2 Accident 3 Suicide	ertification: T	After th	Division
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) (Check one) (Check one) (Check only one) (Check one) (Ch					of examination and/or in	miner: On the basis of		(Check only 2		24 hours a Funeral I	
and manner stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, 1)  28c. License number  29d. Date signed (Month, Day, 1)	(Month, Day, Year)	29d. Date signed (A	_		mo	midlet	tle of certifier		Me	within <b>To the</b> compl	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John W. Middleton L& Poole Rd Winterinsten MD 2157	157	oter MD 211	Westminet		leath (Item 23a) (Type,		ss of person who	30. Name and addres			
State Registrar  31. Date filed (Month, Day, Year)  FEB () Q 2010  32. Registrar's Signature		,	· · · · · · · · · · · · · · · · · · ·	ale	rar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dvr g900 2-9-10 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ Year 2010 4:37 PM 5 Helen Grace Stapf Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, ep 16, Months Days Hours Min. 83 1926 Maryland Director 213-32-2976 Sep Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 🗷 No MD Lutherville Timonium Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 United States 3 Dodworth Court death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ρ hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 Tho Specify. Specify: 3 - Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Histologist Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Lewis F. J. Stapf Grace Emmerich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Gail Smith /Cousin 6434 Cloister Gate Drive Baltimore, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb 09 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 2010 4 Donation 5 Other (Specify) Chesapeake Crematory 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Dater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final OR Physician/ ULMONAL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death as been signed by the 2 should be detached 9 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUMMIENC 1 √ es 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2 000 Hospital Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2( Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar FOINCHAPLES STI BATTUNKEIMO 21204

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEW.
31. Date filed (Month, Day, Year)

BOBY RINAW, MS

Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

			ite of Maryland /	Depar		ealth and N	Mental Hygi	ene g. No. 2	0 03366
Physici: /Medic		1. Decedent's Name (First, Middle, Last) GERTRUDE			SEWE		2. Date of Death Month	03 ZOI	0 03:00 AM
Funeral Director	ier	4a. Facility Name (If not institution, give street  Howard County Gener  5. Social Security Number  213-26-4988  6. Sex  1 □ M 2	al Hospital	birthday)	4b. City, Town, or  Columb  If Under 1 Year  Months Days	ia If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 9,	4c. County of Do Howar  Year) 9. F	
	Director	Usual Residence of Decedent  10a. State 10b. County  MD Howard	10c. City, To	own or Loca	bia				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ath with the S 23a or 2	eral Dire	10e. Street and Number 6334 Cedar Lane	Description in 110	140.144		1044		USA	merican Indian,
72 hours after death with the Maryland natural", or items 23a or 28a-f show dicel Examir or must be redified at	d by Funeral	1 Never Married 2 Married 1 if	as Decedent Ever in U.S. med Forces? Yes 2 X No 'es, Give ar or Dates:		as Decedent of Hi Yes, specify Cuba □Yes 2∏ No	spanic Origin? (Sp n, Mexican, Puerto Specify:		Black, W	hite, etc. olack
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s 1 and 2 should be filed within Health and Mental Hygiene. Item 27 is marked other than other traumatic event, It a IM	To Be C	17. Father's Name (First, Middle, Last) Samuel Israel Crump				Helen		a Mathews	
1 and 2 shu Health and em 27 is m		19a. Informant's Name/Relationship (Type. Pr Alvis Gunn/son	, , , , , , , , , , , , , , , , , , ,	203 R		un court	hanover	City or Town, State  MD 210  Oc. Location - City	)76
permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau	ļ,	1 ☐ Buria! 2 ☐ Cremation 3 ☐ Remove 4 ☑ Donation 5 ☐ Other (Specify)	al from State	etery, crema	atory or other place				
Department of the permuent of		21. Signature of Funeral Service Licensee  Ronal a S. Wadd  23a. art1. En er the disease, or c. mplication	s that caused the death. D	Ba.	ltimore,	MD = 2120	1	Baltimore	Approximate
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te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, Louring to in modest cause. Enter Underlying Cause (Disease or injury that initiated events c	OSTEOMY The to (or as a consequence)	eliti	ı				1 Month
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ician: The law re certificate has bee ector, page 2 sho	e Completed	25. Was case referred to medical		<u>-</u> .		00 Plans of Pass	24a. Was an autopsy perform 1 □ Yes 2	/ prior ned? deat I⊋No 1 □	e autopsy findings available to completion of cause of h? Yes 2 17No
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certified completely filled in by the funeral director, t	Certification: To Be	examiner?  1 Yes 2 No Hospita  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 28.	a. Date of Injury (Month, Day, Year)  28  28  28  28	b. Time of Injury	28c. Injur Work M 1 🗆	er: 4□ Nursing H y at	ome 5 Resider 28d. Describe how	nce 6 Other (swinjury occurred	Specify) r Rural Route Number,
Hospital or / 4 hours after Funeral Dire ely filled in b	edical Certif	4 ☐ Homicide  29a. Certifier (Check only 2 ☐ Medical Examiner: 0	building, etc. (Specify)  I: To the best of my knowled the basis of examination	dge, death	occurred at the tir		City or Town,	, State)  ause(s) and manne	er as stated.
To the I within 2 To the I complet	Medi	29b. Signature and title of certifier  30. Name and address of person who complet	ed cause of death (Item 23	sa) (Type, P	29c. License <b>D</b> 62			Feb 03	10nth, Day, Year) 3 ZO10 21044
Sta	ite	MICHAEL DRVMMOND  31. Date filed (Month, Day, Year)  FEB 0 9 2010	10724 ( 32. Registrar's Signature	hose	Patu xen	+ Parkn	ray Colu	mbia, Ml	21044
Registr	rar	FEBUS ZUIU	and the last	7					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 27, Armatha E. Shriner 2010 January 9:00 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 126 W. 4th Street Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 214-12-4039 Mary Tand Jan 31, Director 1921 88 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho Directo 1∐Yes 2**X**∑No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21701 126 W. 4th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ₽ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 11 own home h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Miriam Catherine Fogle Allen Smith Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl
Department of Health an
Important: If item 27 is 1
any Injury or other trau Marquita Staley/daughter P.O. Box 123 Hamilton, VA 20159 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4M Donation 5 ☐ Other (Specify) 21. Signature of Funeral Prvice Licensee Ronald S. Wade, 22. Name and Address of Facility Virector State Anatomy Board 655 W. Baltimore Street 23a. Part Enter the disease; or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. inn Approximate Interval Between Onset and Death Immediate C = e (Final disease or condition resulting in death) CANCER **Physician** con /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate performe Division of Vital 1 ∐ Yes 2.2 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1.X Natural 2 ☐ Accident 5 Pending death. nours after death.

neral Director: / investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the I 29b. Signature and the of certifier 29c. License number D0055061 who completed cau West Ninth Street; Frederick, MD 2170 ind address of persor se of death (Item 23a) (Type, Print) AUBRIE NA64 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Mundi Schnitzer Medical February 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 D Months Hours Min (Month, Day, Year) 215-88-0613 48 **Director** July 27, 1961 Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1021 Overbrook Road 21239 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene of Health and Mental Hygiene If item 27 is marked other the other traumatic event, the 12 <u>Administrative Assistant</u> Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Anthony Winogrodzki Margaret Schafer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 1021 Overbrook Rd., Baltimore, MD 21239 permit. Page 1 and 2 st Department of Health as Important; If item 27 is any injury or other tran-Jeffrey Jay Schnitzer / Husbard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 2/9/2010 Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) north s 5mall cull cancer 100 lung Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sician a Physician/Medical Box 68760 phy attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year the 9 Unknown 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, se i Zures 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed?/ Yes 2 N 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician; funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, Kalton D0069536 Feynan 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Black Balkmore

State Registrar

			Amedn #2	Please , per	Type or F	Print in 2/9/1 Maryla	Black in 10 TT nd / Depa	delible Ink	. Ensur Health ar	e All Copie nd Mental H	s Are	Legible.	
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			1. Decedent's Name (Fi	irst, Middle, La	st)					2. Date of D	eath		3. Time of Death
22	Physic /Medi		Harvey St	urtevan	t					Month	7.4	y <b>2010</b> Year	M GOPI
-1.4	Exami		4a. Facility Name (If not	-		nber)		4b. City, Town, o	or Location of I	Death	4c	. County of Dea	ath
~			610 Sherwo					Sal	isbury			Wicomic	
	Funeral Director		5. Social Security Numb	er 6. S	ex M 2□ F	7. Age (In yrs 8.	s. last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, L	irth Day, Year)	9. Bir	rthplace (State or Foreign ountry)
			Usual Residence of Dec			0.	3			Feb 4	, 192	6 New	Hampshire
	how	L	10a. State 10b	b. County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	Director	MD W	Vicomic o	0		Salis	oury					1 ☐ Yes 2√ No
	vith th	Dire	10e. Street and Number		1 -			10f. Zip Code	21804		10g. Cit	izen of What Co USA	ountry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Exactions and be notified at	Funeral	610 Sher	wood C.			10 100						
	iter de	Fu	11. Marital Status 1 ☐ Never Married	2□ Married	12. Was Deced Armed Ford 1 ☑XYes 2	ces?	J.S.   13. \	Vas Decedent of F Yes, specify Cub	Hispanic Origir an, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	lo-	14. Race - Am Black, Whit	
936	urs al	þ	3 ☐ Widowed 4 💢		If Yes, Give Year or Dai		-46	□Yes 21XNo	Specify:			Specify:	white
5-0	72 ho natur fical	Completed	15.	Decedent's Ed	ucation		16a. Deced	ent's Usual Occup kind of work done	pation	f	16b. K	ind of Business	/Industry
121	ithin ne.	ם	Elementary/Secondary		College (1-4	4or 5+)	life. E	OO NOT use retire	d) -	working			
2	iled w Hygie ther t nt, th		12 17. Father's Name (First	t Middle Last)	4		<u> </u>	ostal wo		N (5: 1 10:-1-11			1 system
au(	d be f ental I red of	Be C	17. Fauler's Name (First	i, Middle, Lasi)				unk	18. Mother's	Name (First, Middle	e, Maiden	Surname)	unk
$\mathbf{Z}$	should nd Me mark	욘	19a. Informant's Name/F	Relationship (	Type, Print)		19h Mailin	n Arldross (Stroot	and Number	or Rural Route Num	har City	r Town State	Zin Codal
Ž	nd 2 ; alth a 27 is r trau		Karen Gunz		. ,					Road New			
ore,	of Hear		20a. Method of Disposition	ion			Place of Dispos			Date New		ocation - City or	
<u><u>Ĕ</u></u>	Page nent ant: If ury or		1 ☐ Burial 2 ☐ Cre 4 ☐ Donation 5 🔯	emation 3 ☐ Other ( <i>Specif</i> )	Removal from St	ate	cometery, crem	atory or other plac					
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exa., it wit ritual be notified at once.		21. Signatur of Funeral Konta				r St	Name and Addre	ess of Facility	ard 655 W	b Roll	timoro	Ctroot
_	90 E 49 9		1000	1/1/1/	XLL		Ba	Itimore.	MD 21	1201		LIMOTE	Street
			23a. Part 1 Enter the dis shock or heart fail	lure. List only o	ilications that cau one cause on eac	used the dear ch line.	th. Do not ente	r the mode of dyir	ng, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
Ton't	hysician / /Medical		Immediate onuse (Final disease or condition resulting in death)	_	a		ASCUT	)					Onset and Death
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90	e be executed sician and burial-transit		resulting in death) Last			as a consec	quence of):		<u> </u>				
	death certificate to attending physical for use as the b	Physician/Medical			d		<u>.</u>						
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Вох	death certificate e attending phys d for use as the	cian	23b. Was decedent preg	ths?	1 ☐ Live bir	th 2☐ Feta nt at time of	aldeath 3 □	Ectopic pregnanc Other (specify)	у		1	23d. Date of de Month	livery Day Year
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₹ .	certificate rector, pag	Be	25. Was case referred to examiner?	-	· · · · · · · · · · · · · · · · · · ·					Death (Check only			
<b>o</b>	r this certific ral director,	2	Yes 2 No				ER/Outpatient		4 LI Nursir	ng Home 5 Res			cify)
0	aing h. After funer	Ę.		Pending investigation	28a. Date of (Month,	Day, Year)	28b. Time of Injury	28c. Injur Work	yat <br Yes 2 ⊟No	28d. Describe	how injury	y occurred	
DIVISION	Atten r deat ctor: y the	fica		Could not be determined	28e. Place of	Injury - At ho	ome, farm, stree	et, factory, office	res Z 🗆 No	28f Location /	Street an	d Number or Ri	ıral Route Number,
5	s afte	Certification: To	4 ☐ Homicide	determined	building	, etc. (Specif	<i>(y)</i>			City or To	wn, State	)	rar route Number,
	t hour inners		29a. Certifier 1 ☐ (Check only 2 ☐ 1	Certifying Phy	sician: To the be	est of my kno	owledge, death	occurred at the tir	me, date and p	lace, and due to the occurred at the time,	cause(s)	and manner as	s stated.
4	one nospinal or Autending Prysician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		1	and manner	r stated.				occurred at the time,			
, i	8 <b>4</b> <u>8</u> <del>2</del>	-	29b. Signature and title d					29c. License	o49)			e signed (Monti	h, Day, Year)
		-	30 Name and address of	nerson who	) omploted acces	of dooth /lt-	020\/T	1 , 1 ,				./10	
			30. Name and address of		.O. OV	uE	100 E Car	1011 St.	Sal	is buy, m	2	21842	
	Stat	е	31. Date filed (Many), Da	ด้วกาก	32. Reg	istrar's Signa	ture	2	0-11	150004, 111.			
	Registra	r	1 FD (	O LUIU	Len	Ju.	Par Comment						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Sadler, Jr Edward William February 2010 9:56 P /Medical 4 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Year | If Under 24 Hrs. Carroll Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F Months Days Hours Min 80 Yrs. **Director** 217-26-5360 10, 1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Nedical Examiner must be resulted. 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Frederick Mt. Airy 10e Street and Number 10g. Citizen of What Country? Funeral 14829 Black Ankle Road 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 printer commercial contracts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ္ပ Edward William Sadler, Sr. Christine Kramer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine A. Sadler/ wife 14829 Black Ankle Rd. Airy, MD 21771 20c. Location - City or Town, State Mt. Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2/8/2010 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature Funeral Service Ligens a Xaria 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a y lead of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the buria Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours af Euneral D etely filled in deatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier one) the within 7 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) D0067468 5/10 30. Name a rson who completed cause of death (Item 23a) (Type, Print) Mohit buth Couter Street USTMIUSTER MID 21157 NATANO

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State Registrar

FEB 0 9 201

31. Date filed (Month, Day,



**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year Judith Weston Shepp 14544 /Medical 2010 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Agnes Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) 11/14/31 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Months Vear) 1 □ M 2 🔭 F Days Hours Director 213-30-9260 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be reserved. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 1101 Oakland Terrace Road Funeral 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ٤ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Technician Northwest Hospital 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Malden Surname) William Ulrich ပ္ Mary Helen Jory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Donald L. Weston, Jr. / Son</u> 826 Templecliff Rd. Pikesville, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 2/15/10 Baltimore, Maryland 21. Signature of Funeral Service Line 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enjer the disease, or of shock, of heart failure. List plications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preumonia 2 Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Da Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trar Due to (or as a consequence of): physician s the burial P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 2 No **Division of Vital** 2 □No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 5 ☐ Pending investigation 28d. Describe how injury occurred 1 Natural 2 Accident Hospital or Attendii 24 hours after death. E Funeral Director; A 1 □ Yes completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. D 24064 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 2AR Cation Baltimore 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	larylan	•		of Healtl of Death		Mental Hy	_	20	110	02271
	Physicia	an/	Decedent's Name (First, Mide					_	•	2. Date of De	Reg. No. ath Day	<u> </u>	Vacr	3. Time of Death
1	Medic	cal	4a. Facility Name (if not institution	ERNE.	57	7	T	LOR own, or Location	a of Dooth	2. Date of De Month		4	Year /	950 PW
1	Examir	ier	1201 Hollins	,				own, or Location timore	on of Death		4c. (	County	of Death	
	Funeral Director		5. Social Security Number 268-18-8442	6. Sex 1 🛣 M 2 □ F	ge (In yrs. Ia 93	ast birthday) Yrs.	If Under Months	1 Year If Und Days Hours	der 24 Hrs. s Min.	8. Date of Bir (Month, Da 07/26/	th 1916		9. Birthp Count Ind	lace (State or Foreign rx) 1 a
	and show	ō	Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. Cit	y, Town or Lo	cation		_		•		10	Od. Inside City Limits
	Maryla 28a-f otified	Director	MD		Ва	ltimor	e							1 🔀 Yes 2 🗌 No
	th the 3a or t be n	alD	10e. Street and Number	T		-	10f. Zip (				10g. Citiz		hat Count	try?
	ems 2	Funeral	1201 Hollins  11. Marital Status	12. Was Decedent			Was Decede	21209	Origin? (Sp	ecify Yes or No-	Tı	U.S	- America	an Indian.
Maryland 21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	٥	1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorce	If Van Cive			f Yes, specif	y Cuban, Mexic	can, Puerto	Rićan, etc.)		Black	White, e	tc.
15-0	72 hou 1 "natu ledica	Completed	(Specify only hig	lent's Education hest grade completed)		(Give	kind of work	Occupation done during m	ost of work	king	16b. Kin	nd of Bus	siness Ind	ustry
212	ed within Hygiene.		Elementary/Seconday (0-12)	College (1-4 or 5+	5+)		о <i>моти</i> se <i>i</i> aher Н	retired) Educatio	on		   Pub	olic	Неа	l+h
pu	filed valued by tal Hyg	To Be	17. Father's Name (First, Middle	,			,	18. Mc	other's Nam	ne (First, Middle,	Maiden S	urname)		
ryla	2 should be file Ith and Mental 27 is marked o traumatic eve	-	John C.  19a. Informant's Name/Relation	Taylor		1.0			izabe			Seih		
	Ø ≡ Ø ⊑		Henry Taylor			1	-			al Route Numbe ltimore				ode)
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3 🗆 Removal from State		Place of Dispo emetery, crer	sition (Name	e of ner place)		Date	20c. Loc	cation - (	City or Tov	vn, State
Iţim	permit. Page 1.4 Department of H Important: If ite any injury or ot	l l	4 🔀 Donation 5 ☐ Other	(Specify)		tany Gi				/2010				aryland
Ba	permit Depar Impor any in		21. Signature of uneral Service	Licensee						atomy G . Ste.		-		7 1D 21076
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that cause t only one cause on each lin	d the deatl e.									Approximate Interval Between
	Physician, Medical	2 9	Immediate Cause (Final disease or condition resulting in death)	a. PR	05	TAT	EC	AN	CER	e w	172			Onest and Double
H	Examiner		resolving in dodary	Due to (or as	a consequ	ience of):	one,	Lun	7 r	E W	1	nex	asta	11
	л #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as										
8.	xecute n and al-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as	a consequ	ience of):							+	
092	cate be executed physician and s the burial-transit	edical		d										
3876	rtificat ling ph e as th	/Mec	IF FEMALE:	00- 16									_1_	
. Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	ıldeath 3 [	Ectopic pro Other (spe				2:	3d. Date Mon	of deliver	y Day Year
P.0	that the need by e detac	by Pr	Part II. Other significant condit	tions contributing to death t	out not res	ulting in the u	nderlying ca	use given in Pa	art I.					cause of death?
rds,	equires een sig ould b									1 🗆	Yes 2 🗷	No 3	B 🗆 Proba	ably 4 🗌 Unknown
Division of Vital Records, P.O.	The law re cate has be page 2 sh	Completed										pr de		sy findings available upletion of cause of
İta	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				26. Place of D						
of V	g Physer this neral di	te: To	27. Manner of Death	28a. Date of inju	iry	ER/Outpatier 28b. Time of		c. Injury at		ome 5 Sesion 28d. Describe h				
on	eath. or: Aft the fur	Certificate:	1 Natural 5 ☐ Penc 2 ☐ Accident Inves 3 ☐ Suicide 6 ☐ Coul	tigation	y, rear)	injury	М	work?	□No	_				
Divis	ital or At urs after o ral Direct lled in by	al Cert	4 ☐ Homicide deter	mined 28e. Place of Injury	c. (Specify,	)				28f. Location (S City or Tow	n, State)			,
	e Hosp 1 24 hor e Fune eleted fi	Medical	(Check 2 ☐ Medical	ng Physician: To the best of Examiner: On the basis of e ng Nurse Practioner To the	xamination	and/or invest	igation, in my	y opinion, death	occurred a	t the time, date a	nd place, a	and due t	the caus	e(s) and manner stated.
_	To the comp	173	29b. Signature and title of certification	er			29c. l	icense number	r		29d. Date	signed (	Month, Da	ay, Year)
			Thurs 12	Tople	- M	omp	4 5	7002	743	5 4	2/	15/	120	10
	\		30. Name and address of person  31. Date filed (Month, Day, Year)	wno completed cause of d	eath (Item	23a) (Type, F	NS L	ANE	BA	2771	OR	£.	mp	2/209
	Stat Registra	•	FEB 0 9 20°	O Deven	J. y	barke	5							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of M Registrar		artment of Healt rtificate of Dea	tn and Mental Hy <i>th</i>	giene Reg. No. 2010	03373
	hysici: /Medic		1. Decedent's Name (First, Middle, Last)  ALICE TA	TES		2. Date of De Month	ath 3ay Zolo	3. Time of Death
-	xamin		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or Locati		4c. County of Deat	70-
	ineral rector		218-44-6344 <sup>1□ M 2</sup> ▼F	: Hospital ge (In yrs. last birthday) 65 <sup>Yrs.</sup>	Randallst   If Under 1 Year   If Under 1 Year   Hou	der 24 Hrs. 8. Date of Bir	Baltin th 9. Birt ay, Year) 9. Birt Co 1944 Mar	nore thplace (State or Foreign puntry) yland
Maryland	f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. City, Town or Lo				10d. Inside City Limits 1∏Yes 2 □ No
with the l	3a or 28a st be notif	al Director	10e. Street and Number 4206 Colbourne Road		10f. Zip Code 2122	9	10g. Citizen of What Co	untry?
Idal y Idalid ZIZIS-0030 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene.	Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It w Mutical Evarance must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ▼Widowed 4 □ Divorced  12. Was Decedent Armed Forces  1 □ Yes 2 □ Xif Yes 3 □ Xif	No	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □Yes 2XI No Spec	c Origin? (Specify Yes or No kican, Puerto Rican, etc.) cify:		
LILIO-U	r than "natu the Mudical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4ors 12 0	(Give	dent's Usual Occupation kind of work done during r DO NOT use retired) Secretary	most of working	16b. Kind of Business/	Industry unk
d be filed ental Hyg	c event,	Be	17. Father's Name (First, Middle, Last)  Elmer Johnson			other's Name (First, Middle,	,	
2 should	is mark raumati	2	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street and Nu	ımber or Rural Route Numb		Zip Code)
Pages 1 and nent of Health	ant: If Item 27 ury or other t		Antoinette Tates/daughter  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 ☒ Donation 5 □ Other (Specify)		6 Maybin Cir psition (Name of matory or other place)	cle Owings Mi	111s, MD 21 20c. Location - City or	117 Town, State
permit. Departr	Importa any inju once.					y Board 655 W		Street
/Me Exar	g pnysician and as the burial-transit as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):  a consequence of):	ter the mode of dying, such	h as cardiac or respiratory a	rest,	Approximate Interval Between Onset and Death
auth cer	ed for use	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
quires that	pe de	ed by Phys	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderfying cause given in Pa		obacco use contribute to	
	tor, page 2 should	Completed				1 □ Yes	prior to death?	utopsy findings available completion of cause of
) <u>S</u>	direc	To Be		ent 2 ☐ ER/Outpatier	Othor:	lace of Death (Check only o	1411	Spill
- E	nuera nuera	Certification:	27. Manner of Death  1 Natural 5 Pending (Month, ba)  2 Accident investigation  3 Suicide 6 Could not be	2	Work? M 1 □ Yes 2	2 □ No	now injury occurred	
To the Hospital or Attendi within 24 hours after death.	illed in by		4 Homicide determined 20e. Place of in building, et	ury - At home, farm, str c. (Specify)		City or Tou		
the Host on 24 hor	mpletely f	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in	vestigation, in my opinion,	death occurred at the time,	date and place, and due	to the cause(s)
Towit	2 00		29b. Signature and time of softlier	ohn	29c. License numb	872 F	29d. Date signed (Month	
				b 283	Print) Smi	Ky Aces	· W 2	20/0
В	Stat egistra		31. Date filed (Month, Day, Year) FFR 0 2010	ar's Signature	red .			NO. OF

Amend #26, per DVR g900 2/9/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 **Physician** 1:58 A M elen Marie Turnbau 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 2119 Gaylawn Dr. Lansdowne Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, June 30 **Funeral** Year) Months Days Hours Min 1 □ M 2 □ F Director 214-56-9432 85 Yrs. 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm M dical Exart incommatic event, I'm M dical Exart incommatic event, I'm M Director 1 ☐ Yes 2 ☐ No MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2119 Gaylawn Dr. 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □Yes 🔏 □ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white 2 Specify Specify 3 X Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Garfield Ford Bessie Rebecca McFadden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Shannon Groom/granddaughter 2119 Gaylawn Dr., Lansdowne, MD 21227 permit. Pages 1 a
Department of He
Important: If Item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 2/9/10 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Gardens Ellicott City, MD Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral S Michael J. Flagle 23a. Part 1. Effective disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WIMM AV **Physician** /Medical Due to (or as a consequence of): Examiner Un MQ Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and -trar burial-t Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Day Year detached the 9 Unknown signed by Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ pe Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy To the Hospin...
within 24 hours after death.
To the Funeral Director: After this certificate
"moletely filled in by the funeral director, par performe 1 □ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5-Residence 1 ☐ Yes 2 ☑ 1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signat re and title of 29c. License number 29d. Date signed (Month, Day, Year) 2010 Name and address of po completed cause of death (Item 23a) (Type, Print) Rd, Ste 210, Catonville MD 21228 +NMIR 40 31. Date filed (Month, Day, Year) FEB 09 State Registrar

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malinin Alex:

29b. Signature and title of certifier

Malinin

32. Registrar's Signature

M. D. 9000 Frank

State

29c. License number

00000

29d. Date signed (Month, Day, Year)

2.4.10

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chala	partment of Health and Mental ertificate of Death	Hygiene Reg. No. 2010 03376
	Physic		1. Decedent's Name (First, Middle, Last)  MARY VARACALL	2. Date Monti	of Death
-	/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
and a			Genesis Perring Pkwy.	Parkville	Balto.
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K 7. Age (In yrs. last birtha	Months Days Hours Min. (Mont	of Birth h, Day, Year)  9. Birthplace (State or Foreign Country)
			212-07-0368 94 Yrs Usual Residence of Decedent	Octob	per 6,1915 Maryland
	arylan show	_	10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
	he Ma 28a-f	Director		Perry Hall	1 ☐ Yes 2 ŽŽNo
	with t	ij	10e. Street and Number 8918 Quail Run Dr.	10f. Zip Code	10g. Citizen of What Country?
	death ms 2%	Funeral		21128  3. Was Decedent of Hispanic Origin? (Specify Yes)	USA or No- 14. Race - American Indian,
9	or ite	E.	Armed Forces?  1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 ☐ No   1 ☐ Yes (Sive	3. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	
000	hours ural",	d by	3 X Widowed 4 □ Divorced Year or Dates:	1 □Yes 2 X No Specify:	Specify: White
15	in 72 n "nat	plete	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
212	d with giene er tha	Completed	College (1-40r5+)	emaker	Home
pu	be file Ital Hy Id oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mi	
Maryland 21215-0036	d Mer d Mer marke	ဥ	Joseph Armiger	Mamie St	
Ma	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Everninar Trust be notified at			iling Address <i>(Street and Number or Rural Route N</i> .8 Quail Run Dr. Perr	umber, City or Town, State, Zip Code)  'Y Hall, Md. 21128
Baltimore,	of Hear		20a. Method of Disposition 20b. Place of Dis	position (Name of permatory or other place)	20c. Location - City or Town, State
Ë	permit. Pages 1 a Department of He Important: If item any injury or oth		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayvier	•	Balto. Md.
3alt	ermit. Pepart Mport ny inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Schimu	nek Funeral Home
	20 = et 0		ferent C		gham, Md. 21236
	Dharistan		23a Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	. 660	ory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Conclotive F  Due to (or as a consequence of):	eart failure	years
	Examiner		Pulmanagul	Hypertension	LIEGY
	ed sit	iner	if any, leading to immediate Due to (or as a consequence of):	<b>V</b>	7 - 7
W.	xecut	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	enosis - critical	years
8760,	ficate be executed physician and s the burial-transit	dical E	d		
68	rtifical ng phy as th	Medi	15 SELVIS		
Вох	eath certific	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy	23d. Date of delivery
P.O. I	or Attending Physician: The law requires that the death certification after death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached or use as	Physician/Me		Other (specify)	Month Day Year
<u></u> ج	that the ned by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. D	)id tobacco use contribute to the cause of death?
Vital Records,	w requires s been sig should be	Completed by	End stage renal disea	. S e 1	☐ Yes 2,2 No 3 Probably 4 Unknown
၁၁	e law re has be	blet	0	24a. V	Vas an 24b. Were autopsy findings available
E E	sician: The certificate h rector, page	6		p	utopsy prior to completion of cause of death? s 2 ☑ No 1 ☐ Yes 2 ☐ No
Vit.	sician: The certificate rector, pag	<b>C</b>	25. Was case referred to medical examiner?	26. Place of Death (Check or	
o i	y Physer this eral di	٥ -	27. Manner of Death 28a. Date of Injury 28b. Time	- Inditional of the state of th	desidence 6 Other (Specify) be how injury occurred
ioi.	Attending F death. ctor: After y the funer	atio	1 Matural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	of 28c. Injury at 28d. Descri Work? M 1 ☐ Yes 2 ☐ No	be now injury occurred
Division	ial or Attendir s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 28f. Locatio	n (Street and Number or Rural Route Number, Town, State)
	pital o				
6	within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, der and manner stated.  Certifying Physician: To the best of my knowledge, der and manner stated.	th occurred at the time, date and place, and due to nvestigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	Vithir Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			sama mawafa	00058965	February 4th 2010 Road
		3	30. Name and address of person who completed cause of death (ftem/23a) (Type SAIMA KHAWAJA M. S.	Print) 1801 Wentworth Baltimox MD	Road
	Stat	e 3	31. Date filed (Month, Day, Year) 32. Registrar's Signature	baltimox MD	4125-1
	Registra	r	## 0.9 2010 Sente S. A.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year Francis L. Vain 26 January 2010 10:01 P /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10002 Perine Lane Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, )
June 22, **Funeral** 9. Birthplace (State or Foreign Year 1 M 2 □ F Months Days Hours Min Director 75 Maryland 212-32-0175 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any hiury or other traumatic event, the Modital Engineer must be retilified at once. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 □Yes 2√□No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10002 Perine Lane 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: 3 X Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) shipyard worker shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry D. Vain ၉ Ethel S. Vain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard D. Vain/son 10002 Perine Lane Parkville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ ther (Specify) 21. Signature of Funeral Stryice Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ut1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or Indition resulting in eath) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as certificate has been signed by the attending rector, page 2 should be detached for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 5 ☐ Other (specify) 2 No 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Des 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 1 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manny of Death 1 | Natural 2 | Accident After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 790

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 **201**0

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Estela Beatriz Vaca de Welch 2. Date of Death Physician/ Month Beatris-Welch February 5:35 P M <del>Estela</del> 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Ecuador **Funeral** Dec 20, Year) Days 1 □ M 2 □X Months Hours Yrs Director 231-61-9640 84 Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 🗆 Yes 2 🕱 No Maryland Howard Ellicott City 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13314 Springwood Court 21042 Ecuador 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ٥ 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Ecuador Baltimore, Maryland 21215-0036 "natural", Specify: Completed 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner <u>Agriculture</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ပ္ Eloy Vaca Isabel Lara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i George A. Ricaurte/son 13314 Springwood Court Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1
Department of Important: If it any injury or o once. ŏ 1 Burial 2 🔀 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/5/2010 Woodbine, Maryland 21. Signal re of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be attending p for use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 Do ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARKINSONS DISEASE 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 I within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation Accident
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my colo Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 264395 FEBRUARY 3. 2010

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital Records,

6701 NOVAPLES ST, SUITE 4105 BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO

FEB 0 9 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			■ State	epartment of Health an Certificate of Death	, ,	iene <sub>eg. No.</sub> 201 (	1 13379
	Physicia	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death
	Medi		Oliver Newton Ward		Month Februar	v 1. 2010	9:15 P M
	Examir	ner		4b. City, Town, or Location of De	eath	4c. County of Dear	
	Funeral	-	9501 49th Place 5. Social Security Number   6. Sex   7. Age (In vrs. last birthe	College Par		Prince	George's
	Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Months Dave Hours M	in. (Month, Day,	Year) 9. Bir	thplace (State or Foreign unity) hington, DC
	, MC		Usual Residence of Decedent		10ct 15,	1921   Was	nington, DC
	yland -f sho ed at	턍	10a. State 10b. County 10c. City, Town of				10d. Inside City Limits
	e Maı r 28a notifi	Director	Maryland Prince George's	College Park			1 🔀 Yes 2 □ No
	ith th			10f. Zip Code	1	0g. Citizen of What Co	ountry?
	ems	Funeral	9501 49th Place  11. Marital Status 12. Was Decedent Ever in U.S.	20740	(2)	United S	tates
9	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at			<ol> <li>Was Decedent of Hispanic Origin?</li> <li>If Yes, specify Cuban, Mexican, Pu</li> </ol>	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
933	ural", ural",	ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1942–46	1 ☐ Yes 2 🗽 No Specify:		Specify: W	hite
21215-0036	"nat	Completed by	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupation live kind of work done during most of w	vorking	16b. Kind of Business	Industry
12	within 7 giene. er than , the M	Š	Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired)	VOIKING		
9	led w Hygiv other ent, t	Be (	10 17. Father's Name (First, Middle, Last)	Mechanic		Bicycle	
Maryland	l be filed lental Hy rked oth tic event	မ	Herbert Burbank Ward	Ada Ada	Name (First, Middle, Ma		
ary	should and Me is marl raumati			lailing Address (Street and Number or	Elizabet		0-4-1
	and 2 s Health s tem 27 i					Maryland	
ore	e 1 aı of Hi liter		20a. Method of Disposition 20b. Place of D	sposition (Name of crematory or other place)		20c. Location - City or	
Ē	Page tment o tant: If jury or		4 Donation 5 Other (Specify)	ourney Crematory 2	2/5/2010	Woodbine,	Maryland
Baftimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee  M00957	Name and Address of Facility Ing Home Cremati	ion Service	P.O. Box	784
			23a. Part Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	Beverly L. Heckrot enter the mode of dying, such as cardi	ac or respiratory arrest	JIAIKSVIIIE	Approximate
	Ph_sician/		Immediate Cause (Final	200200			Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  a. Aspiration Fno Due to (or as a consequence of):	HICHIA			days
		-c	Cerebrovascular	Accident			days
	ed Isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury				
	executed an and rial-transi	Exa	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
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	certificate nding phys use as the	Med	IF FEMALE:				
89 x	h cert tendir r use	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	B ☐ Ectopic pregnancy		23d. Date of deliv	/erv
Rox	deat the att	Physician/Me		5 Other (specify)		Month	Day Year
<u>.</u>	at the d by t	H	Part II. Other significant conditions contributing to death but not resulting in the	O undarbuing agues alues in Dotal			
, 7.	signe d be o	g P	g to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to t	
or o	been shoul	lete					bably 4 🗌 Unknown
Vital Records,	ne law e has age 2	Completed			24a, Was an autopsy performe	prior to co	psy findings available empletion of cause of
<u></u>	an: The tifficat tor, pa	Be C	25. Was case referred to medical	Of Plans of Posth (Oh	1 Yes 2		2 □ No
<u> </u>	nysici lis cer direc	9	examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 ER/Outpa	26. Place of Death (Chi		e 6 Other (Specify	
0	ng Pł	ij	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time injury injury	of 28c. Injury at	28d. Describe how		<u></u>
VISION	tendi	<u>≅</u>	2 Accident Investigation 3 Suicide 6 Could not be	work? M 1 □ Yes 2 □ No			
<u> </u>	or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural state)	Route Number,
ָ ב	spital nours neral filled	- ea	29a. Certifier 1 Certifying Physician: To the best of my knowledge deat		,		
:	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) Medical Examiner: On the basis of examination and/or inv	PSTIGRTION IN MY Opinion death accurred	of the time date I	deserted to a total	
	vit cor	1	29b. Signature authority of certified	29c. License number		. Date signed (Month,	Day, Year)
•			1.41 Jense M	D0053277		February	4, 2010
			20 News and all the second of	Drint\			
_		ŀ	30. Name and address of person who completed cause of death (item 23a) (Type				
	State		Peter Stengel, M.D. 7525 Greenway	<u>Center Dr. T-4 G</u>	reenbelt,	MD 20770	
	State Registrar	3	Peter Stengel, M.D. 7525 Greenway		reenbelt,	MD 20770	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9perFH, G900, 2/23/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February Year 010 3:19 PM 5, Karen Michele Weeks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Days 1 M 2 DK 44 Hours Min. Oct 20, Year) 965 Director 218-80-3611 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Dundalk 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 2058 Larkhall Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ð 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bar Maid Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Karen Lee Clarke John Leroy Seubert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Hranicka /Daughter 2058 Larkhall Road Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb 08 1 Burial 2 Removal from State Important: It any injury or Department Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives M0144 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final probable hepatic Physician disease or condition resulting in death) Metashit Lancer ontus Medical Due to (or as a consequence of): **↓** Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Patiti Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No Director: After this certificate filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) WOSPLA 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural Natural 5 Pending injury death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after or To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signatur and title of certifie 29d. Date signed (Month, Day, Year)

State

arlow

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARUES

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701 N. Charles

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	of Mary	land / D	epartme C <i>ertifica</i>			and M	ental Hy		2010	1 1	3381
			Registrar  1. Decedent's Name	e (First, Middle, La	est)			Jerunca	te or L	Jean		2. Date of De	Reg. N eath	o. <u>CUII</u>	3. Tim	O O O I
	Physicia Medic		Michael	L Ste	ven	Wall	.ace					Month ひょ	05	Year	3:	OAM
	Examin		4a. Facility Name (if				1	4b. Cit		Location of			4	c. County of Deat		
p. April	Funeral		5. Social Security N	umber 6.5			yrs. last birtho	ay) If Und	er 1 Year	5 Sur		8. Date of Bir	th	Wi com	thplace (Sta	ite or Foreign
- 8	Director		215-62-1	L112	1 <b>⊠</b> M 2 □ F	54		Months	Days	Hours	Min.	02/18	195 195	55 Ma	ryland	<u></u>
	nd now	_	Usual Residence of 10a. State	Decedent 10b. County		100	c. City, Town o	r Location							10d. Insid	e City Limits
	larylar 3a-f sl iffied	Director	MD	Wicom	ico		Biva									Yes 2 🛛 No
	the N a or 28	1 Dir	10e. Street and Nur	<u> </u>					ip Code	-			10g. C	citizen of What Co	ountry?	
	h with	Funeral	3408 Tex	kas Road						L814				U.S.A		
(0	or iter	by Fu	11. Marital Status  1 X Never Marr	ried 2  Married	12. Was Dece		n U.S.	13. Was Dec	edent of Hi ecify Cuba	ispanic Orig in, Mexican	gin? (Spec ı, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, White		1,
203	ırs afte ıral", I Exan	ed b	3 🗌 Widowed		If Yes, Giv Year or Da	/e		1 🗆 Yes	2 🔀 No	Specify:				Specify: B	lack	
15-0	72 hou "natu edica	Completed	(Spe	15. Decedent's ecify only highest g	Education rade completed,	)	1 (0	ecedent's Us Give kind of w	ork done c	ation during most	t of workin	g	16b. l	Kind of Business	Industry	
727	vithin 7 iene.		Elementary/Sec	onday (0-12)	College (1	-4 or 5+)	- 1	<sub>e Do Notu</sub> hicken	,	se Ma	sonry	,	A	gricultu	re	
3 2	filed val Hyg		17. Father's Name (	First, Middle, Last)								(First, Middle,				
yla <sub>I</sub>	uld be Ment narke	유		son Wrig						Yvoni	ne El	izabet	:h W	allace		
√ / Mai	2 sho th and 27 is r traun		19a. Informant's Na	ame/Relationship( Vright /	• • • • • • • • • • • • • • • • • • • •	ther	- 1	_				Route Numbe		or Town, State, Zij 4	o Code)	
Z, Z,	1 and of Hea item other		20a. Method of Disp	position		21	0b. Place of D		ame of			ate		Location - City or	Town, Stat	e
Midk timore, N	Page ment c ant: If ury or			☐ Cremation 3 ☐ 5 ☐ Other (Spec		State	Anatony				02/08	3/2010	На	nover, M	Maryla	ınd
MiV, $\epsilon/\omega_{lpha/L}$ Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of u	neral Service Licer	sue									Registr		1076
	222 40		23a, Part 1, Enter t	the disease, or con	plications that	caused the	death. Do not							Hanover,	Approx	
	Physician/		23a. Part 1. Enter t shock, or hea Immediate Cause (	(Final											Interval	Between and Death
	<b>∕</b> ►Medical		disease or condition resulting in death)	on .	a. Due to	(or as a con	sequence of)	CHACE	1N 0 LL	A	01	- u	100	2		
	Examiner	-e	Sequentially list co	enditions,	b. —	(										
<u></u>	ed	Examiner	if any, leading to in cause. Enter Under Cause (Disease or	riying	Due to	(or as a con	sequence of)									
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	To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 🔑	Certifying Phy Medical Exan	niner: On the bas	sis of examir	nation and/or i	vestigation, i	n my opinic	n, death oc	curred at t	he time, date a	and plac	e, and due to the	cause(s) and	manner stated.
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	Stat Registra			-FR 0.8 5	טוט   🎢	المالية المالية	P. 1	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Pee ANA BD G900 2/25/2010 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 3. Time of Dear 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 9 38 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8820 Walther Blvd #3418 Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1 □ M 2 🔀 F Yrs 033-12-6044 85 Director Dec 26, 1924 Massachusetts Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No 28a-f MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1) letschei or items 23a or 8820 Walther Blvd #3418 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white þ 3X Widowed 4 ☐ Divorced Health and Mental Hygiene. em 27 is marked other than "natural"; Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 registered nurse healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f John Ernest Marsh Pages 1 and 2 should Injury or other traumatic ျှ Augusta Brown 19 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any Injury or other trau once. 610 Nicoll Avenue Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 rector 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and as the burial-tran Due to (or as a consequence of) P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria 700 The law requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 1 □Yes 2 ☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 - Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Liceose number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltun BW. Bruce 32. Registrar's Signature 31. Date filed State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Henry Will February 2010 6:41pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1√2 M 2□ F MD 213-28-9173 78 Dec 1931 13 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the finalical Ever, instruent by muthous MD Carroll Sykesville 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 72 hours after death with 103 Estelle Court 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 124 Yes 2 □ No Kore If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married <sup>2</sup>□No Korea Baltimore, Maryland 21215-0036 1 ∐ Yes 2 🛣 No Specify: white <u>م</u> 3 V Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, Item Mars Elementary/Secondary (0-12) petroleum College (1-4or 5+) systems analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Will Mae Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1242 Hillcreek Rd., Pasadena, MD 21122 William Will III (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2-5-10 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21, Signature of Funeral Service Licensee Day sparght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen sof) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed Exami Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) ed by the detached f 9 Unknown signed | 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of al or Attending P after death. 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical (Check only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registr FEB 0.9 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stumes illet, wb, G190 Georgeton BIVI. Flousbuy MD 21784

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** LOSEPH YOOR 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perring Parkway Nursing Home Baltimore Parkville 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F 219-28-2997 Director March 7. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Parkville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3134 Texas Avenue 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: White Be Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) American Can Company Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be flik trnent of Health and Mental H tant: If item 27 is marked oth Joseph James Yoor Anna Gertrude Rosemary ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Michael Yoor, JR, Son 22 Gun View Farm Ct. Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If iter any injury or oth 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 02/08/10 Metro Crematory Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Stomow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Progressive decune in Conclution **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ALZHEIMER'S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has baan sinned by the American activities. Obstructive
Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) P.O. I ours after death. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Tinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, idronephrosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Sacrul 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Mednulsmman, NP

Frankford Ave. Baltimore,

anera S.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4MD 21206

29d. Date signed (Month, Day, Year)

02/05/10

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	Funeral Director		5. Social Security N 184-05-9	9349	6. Sex 1  M	2 💢 F	e (In yrs. I	ast birthday) 90 Yrs.	If Und Month	ler 1 Year S Days	If Under 24 Hours		3. Date of Birt 04/30/	1919		9. Birth Cour	place (State or Foreign htry) MD
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	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than "dical Examinar must be notified at	Funeral	3004 NO	RTH RIE	GE RO	AD				21043							USA
	death r item iner n		11. Marital Status			Vas Decedent I Irmed Forces? Yes 2 💢		S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Origin In, Mexican, P	n? (Specif Puerto Ric	fy Yes or No- can, etc.)	1		e - Americk, White,	can Indian, etc.
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Maryland	should be file n and Mental H ris marked o raumatic eve	Ш	19a. Informant's Na		hip (Type, Pi	rint)		<del></del>		ss (Street	and Number o		Route Numbe	r, City or	Town, S		
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ore	ge 1 and 2 s it of Health if item 27 i or other tra	Ш	20a. Method of Disp 1 Burial 2		3 X Remo	oval from State	20b. F	Place of Disp ceme <b>rs</b> of	osition (N matory o	ame of other plac	ce)	Da	te	20c. Lo	cation -	City or T	own, State
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Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Fu	neral Service	icensee		>		22. Name	and Addre	ss of Facility	SOL	LEVINS	ON &	BR	OS.,	INC.
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89 89	endin	an/N	IF FEMALE: 23b. Was decedent in the past 12			f yes, outcome			☐ Ectopi	c pregnanc	cy			2		te of deliv	
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S, F	ires the signer of the contract of the contrac	d by											10	Yes 2	□No	3 🗆 Pro	bably 4 Unknown
Records,	v requires been sig should b	Completed											24a. Was				ppsy findings available
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Siol	Attend death ctor:	rtific	2 Accident 3 Suicide 4 Homicide	Invest 6  Could detern		3e. Place of Inj	ury - At he	ome, farm, s	M treet, fact		res 2 🗆 N	_	3f. Location /S	Street and	l Numb	er or Rura	al Route Number,
Division	tal or / rs after al Dire	Ce	4 🗆 Homicide	detern	ninea	building, et							City or Tow				
6	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the Funeral Directors After.  To the Funeral Directors After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical Certificate:	(Check 2	Medical	xaminer:	To the best of on the basis of e ctioner: To the	examinatio	n and/or inve	stigation,	in my opinio	on, death occu	urred at th	ne time, date a	and place,	and due	e to the ca	ause(s) and manner stated.
り	To the within To the COMP	2	29b. Signature and				DOST OF IT	ly Kilowicage		9c. Licens	e number			29d. Date	e signe	d (Month,	Day, Year)
			- /	M	SW	1D			5	747	447			Febr	الشارع	8,	2010
			30. Name and add		who comple	eted cause of c	death (Iten	n 23a) (Type,	Print) a	Y	Colu	mb	l'or V	Nas	4 (0	ind	
	Sta	te	31. Date filed (Mont	th, Day, Year)		32. Registr	ar's Signa	ture	,						-		
	Registr			FFRO	9 201	1 Den	ma.	1	Bar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jänüary 30 2010 10:43 A M Marilyn Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7 E. Washington St; Apt 706 Hagerstown Washington 5. Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 25, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 💢 F 75 Director 1935 Connecticut Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventuals. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 ▼ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 E. Washington Street #706 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 21☑No þ If Yes, Give Year or Dates: Specify: Specify: white 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 clerk retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Lawrence Knight ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Zernosa/half brother 27 Winter Green Drive Quaker Hill, CT 06375 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify) in stat in state 21. Signature of Funeral Service Licens, e 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director 6 Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or ndition resulting in death) Physician Hocardia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Exami physician and the burial-tran Due to (or as a consequence Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No signed by the a 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 2 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Ma r of Death After t 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🔲 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by completely within 2

> Do657285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pilla 31. Date filed (Month, Day, Year) State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examination: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dav. Year)

Medical (

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS#5perFH, G900, 2/18/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Gerardo Eric Francis, Viray Azarcon 2. Date of Death 3. Time of Death Physician/ 2010 рм 6:30 February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Beltsville 7503 Cailen Court cial Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country)
Philippines 565 (Month, Day, Year Apr. 23, 19 1 X M 2 D F Months Days Hours Min. 45 Yrs. Director Usual Residence of Decedent or 28a-f shov 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Me I cal Examiner must be notified at 10a. State 10c. City. Town or Location 10d, Inside City Limits hours after death with the Maryland Director 1 Yes 2 No MD Prince George Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 USA 7503 Cailen Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 asian 1 ☐ Yes 2 K No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry within 72 | d Mental Hygiene. marked other than ' Computer Elementary/Seconday (0-12) College (1-4 or 5+) Programming Software Developer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Health and Mental Health and Mental Health and Marked ot ည Alexander Azarcon Corazon Viray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn L. Azarcon/ Wife 7503 Cailen Court, Beltsville, MD 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Feb. Date 13. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State West Arundel Crem. 2010 Odenton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee to their M01053 313 Talbott Ave., Laurel, MD 20707 kart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Acute Myocardial Infarction Hours Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical requires that the death certificate be Box 68760 as the use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ 5 Other (specify) Month Year Pregnant at time of death Day signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Essential Hypertension 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

To the Funeral Director, After this certificate has to completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 s autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Yes 2 X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) 2 [X No 1 🗌 Yes ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident М Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) D54853 February 08, 2010 who completed cause of death (Item 23a) (Type, Print) 30. Name and Danny E. Lee, MD 1132 Annapolis Road Odenton, Maryland 21113

Registrar
Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 1

32. Registrar's Signature

			a cor	Department of Health and M Certificate of Death	lental Hygiei Reg.	71111	03388
	Physici		Decedent's Name (First, Middle, Last)     PHILIP M. AIDT		2. Date of Death Month FEBRUARY	Day Year 7, 2010	3. Time of Death  12:00 PM.
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 15301 BEAVERBROOK ROAD APT. 3B	4b. City, Town, or Location of Death SILVER SPRING	IBBROART	4c. County of Death	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 219–28–5840 1 🖾 M 2□ F 84		8. Date of Birth (Month, Day, Ye 10/22/19	ar) 9. Birtl	nplace (State or Foreign untry) RYLAND
	iryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	r 28a-f	Funeral Director	MD MONTGOMERY CO. SILV	ER SPRING  10f. Zip Code	10g.	Citizen of What Co	1 Yes 2 No untry?
	23a o	al D	15301 BEAVERBROOK ROAD APT. 3B	20906		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic avant, if a Modical Exactifier resulter notified at 2006.	by Fune	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
15-0036	in 72 hou n "natura Acolcal E	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of worki life. DO NOT use retired)	ing 16b	. Kind of Business/	Industry
2121	filed within Hygiene. othar than "	Com		CHEMIST	C	HEMICAL C	×.
Maryland	should be file nd Mental Hy i markad oth imatic avant	To Be (	17. Father's Name (First, Middle, Last) HARRY AIDT		First, Middle, Maid MEYER	len Sumame)	
	and 2 sho balth and n 27 is m		1.11	Mailing Address (Street and Number or Rura 301 BEAVERBROOK RD.	APT. 3B	ty or Town, State, 2 SILVER SP	rip Code) PRING, MD 20906
Baltimore	Pages 1 and of He ort of He ort. If itam		A Donation 5 Other (Specify)	y, crematory or other place) OLY REDEEMER 2/13		Location - City or ALTIMORE,	
Balti	permit. I Departm Importar any injur		21. Signature of Funeral Service Ligensee MOO217	22. Name and Address of FacilityTHE 8521 LOCH RAVEN BLV	JOHNSON F	UNERAL H	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caus in the conth. Do n shock, or heart failure. List only one caus in each ine.  Immediate Cause (Final disease or condition resulting in death)	not enter the mode of dying, such as cardiac of	or resp rail ry arrest,		Approximate Interval Between Onset and Death
	Examiner		Due to (or as a consequente of Sequentially list conditions	of):			0
	xecuted and Il-transit	Examiner	if any, leading to immediate cause. Enser Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or cause of the consequence or cause or cause of the consequence or cause or				
68760,	icate be executed physician and s the burial-transit	ical	d				
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	the .	the cause of death?
Il Records,	: The law requicate has been page 2 should	Completed	·		24a. Was an autopsy performed	prior to d	topsy findings available completion of cause of 2 No
f Vital	ding Physician: The In. After this certificate ha	To Be	25. Was case referred to medical examiner?  1  Yes 2	Other	n (Check only one) me Residence	e 6 □Other (Spec	cify)
ion of	Attanding Phr r death. ector: After thi by the funeral	ation:	2 Accident investigation	ime of 28c. Injury at Wark?  M 1 Yes 2 No	28d. Describe how in	njury occurred	
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, tor investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Comp	Σ	29b. Signature and tille of certifier	29c. License number	29d.	Date signed (Monti	h, Day, Year)
-1			30. Name and address of person who completed cause of death (item 23a) (	Type, Print) Ford Ned	Certai	SSNA	20106
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 12 2010	park			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Clate of Marylan		tificate of			Reg. No. 2	010	03389
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) OHO Brow	,n				2. Date of De Month	Day	Year	3. Time of Death 5:10 A M
	/Medic	al	4a. Facility Name (If not institution, give s			4b City Town.	or Location of De	eath	<del></del>	y of Death	3 10 7
	Examin		Seasons Hospice	area and nambor)		Randall				timore	
	Funeral Director		5. Social Security Number 6. Sex	M 2□ F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		in. 8. Date of Bi	rth av. Year)	9. Birthp Cour	place (State or Foreign httry)
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimore		y, Town or Loc Randa	cation allstown				1	0d. Inside City Limits 1 ☐ Yes 🏋 ☐ No
	h with the 23a or 28	al Director	10e. Street and Number 3817 Collier Road			10f. Zip Code	1.33		10g. Citizen of	What Coun	try?
920	should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, it a Madical Eventinal must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 □Yes 25 No		(Specify Yes or Nerto Rican, etc.)	o- 14. Ra Bla Speci	ce - Americ ick, White, of fy: Afi	
21215-0036	ithin 72 horan. nan "natur nan "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	dent's Usual Occi kind of work done DO NOT use retir tor Traile	e during most of v ed)	vorking	16b. Kind of E	/	dustry
21	lled will had had had had had had had had had had	S	12th 17. Father's Name (First, Middle, Last)		пас	Mr Harre	1	Name (First, Middle	I		
and	d be fi ental l ked of c eve	o Be	John Lewis Brown					Le Johnson	, , , , , , , , , , , , , , , , , , , ,		
ary	shoul and M s mark umarti	욘	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailin	ng Address (Stree	et and Number or	Rural Route Numi	ber, City or Town	n, State, Zip	Code)
Σ	1 and 2 Health a em 27 is		Esther M. Brown/Wife					allstown, M			
altimore, Maryland	Pages ent of nt; If it		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ilawn Ca	_	2-2	Date 20-2010	20c. Location Woodlawn	, MD	
Balt	permit. Pepartm Importal Importal any Injure once.		21. Signature of Funeral Service License	Weller	92	200 Libert	y Road, R	andallstown	, MD 2113		Balto. Co.
	Physician		23a Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line.  Metastati	0	er the mode of dy		diac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a conseq	uence of):						
λ.	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):						
68760, 🛚	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
P.O. Box 68	ath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	ıl death 3 □	☐ Ectopic pregnal ☐ Other <i>(specify)</i>	ncy			ate of delivionth	ery Day Year
ds, P.	uires that the de signed by the d be detached	by	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause g	given in Part I.		tobacco use co ]Yes 2 ☐ No	ntribute to t	he cause of death?
al Records,	h <b>ysiclan:</b> The law require his certificate has been siç I director, page 2 should b	Completed						24a. Wa auto peri 1 □Yes	opsy formed?		opsy findings available impletion of cause of
<u> </u>	siclan certifi rector	Be	25. Was case referred to medical examiner?	lospital:	15510			Death (Check only		in-e	atient hosaire
on of	ding Phys h. After this funeral di	ion: To	27. Manner of Death 1 □ Natural 5 □ Pending	1 ☐ Inpatient 2 ☐  28a. Date of Injury  (Month, Day, Year)	28b. Time of Injury	f 28c. In	4 LJ Nursin iury at ork? □Yes 2 □No		how injury occu		gitient hospice
Division of Vital	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At houlding, etc. (Special	ome, farm, str fy)			28f. Location City or To	(Street and Nun own, State)	nber or Run	al Route Number,
	e Hospita 24 hours e Funeral letely fille	Medical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To th withir To th сощр	Me	29b. Signature and title of certifier   MS Rajapakse	M.D.			nse number 005740	35	29d. Date sign	ed (Month,	
	1		30. Name and address of person who con N.S. Rajapakse, M.	mpleted cause of death (Iter	m 23a) (Type,	Print) 5-203	, Baltin	nore, M	D. 212	09	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		9					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	State of Maryland / Department of Health and Mental Hygiene  1 - State  Contificate of Death  2 0 1 0 0 2 2 0							
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	ag. No. U U J J J U J U J J J U J U J J J U J J U J U J J J U J U J J J U J U J J J U			
	Physicial Medic Examine		Charles Brown, Jr.			8°, 2010 7:28 PM			
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dear	h	4c. County of Death			
			Washington Adventist Hospital	Takoma Park		Montgomery			
	Funeral	7.	5. Social Security Number 6. Sex 7. Age (In yrs, last birth	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min	_ (Month, Day, \	9. Birthplace (State or Foreign Country) Virginia			
	Director	To Be Completed by F	578-74-8023   150 M 2 L F   59 Y	16.	Jan. 21,	1931 Virginia			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits			
			Maryland Prince George's Hyatt	sville		1 ☐ Yes 2 🂢 No			
			10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Country?			
			5032 37th Avenue	20782	necify Ves or No.	U.S.A.			
<b>.</b>			11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.			
036			3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🛣 No Specify:		Specify: Black			
2-0	2 hour		(Specify only highest grade completed)	Decedent's Usual Occupation 'Give kind of work done during most of wo	rking	16b. Kind of Business Industry			
12	thin 73 the. than		Elementary/Seconday (0-12) College (1-4 or 5+)	ife. DO NOT use retired)		J.S. Postal Service			
р О	ge 1 and 2 should be filed wit to f Health and Mental Hygie : If item 27 is marked other or other traumatic event, the		12 17. Father's Name (First, Middle, Last)	Box Clerk  18. Mother's Na	me (First, Middle, Ma				
an			Herbert Brown, Sr.	Emma Ha	rris	•			
ary			1.7.1	Mailing Address (Street and Number or R					
Σ,			· · ·	10 Foster St., Dist					
Baltimore, Maryland 21215-0036			1 🛛 Burial 2 □ Cremation 3 □ Removal from State Shinoth	Disposition (Name of y, operatory or other place)		20c. Location - City or Town, State			
莊	iit. Parathmer artmer artant injury		4 Oonation 5 Other (Specify) Church  21. Signature of Juneral Service I cens			Petersburg, VA			
Ba	Depi Impo any		Lami Colonia	22. Name and Address of Facility J.M. Wilkerson Fur 102 South Ave., Pe	eral Esta	blishment, Inc. VA 23803			
		лег	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.						
10	nysician/		Immediate Cause (Final disease or condition Atheroscherotic Coronary Anteny disease						
	Medical Examiner		resulting in death)  Due to (or as a consequence of	ŋ;		100.11			
			Sequentially list conditions, b. Due to (or as a consequence or	j <del>.</del>					
برلا	ate be executed bhysician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.						
8	e exectian an	E E	resulting in death) Last Due to (or as a consequence of	η:					
90	ate be	edical	d						
89	sertific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery			
30X	feath (e atter	icia	in the past 12 months?  1 Ves 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year			
P.O. Box 687	t the d by the tacher	by Physician/Me	9 Unknown						
σ.	res that the death certifica signed by the attending pl d be detached for use as t		Part II. Other significant conditions contributing to death but not resulting in	The underlying cause given in Part i.		eacco use contribute to the cause of death?			
ğ	v require been si should b	etec			24a. Was an				
ecc	e law e has l ge 2 s	Completed			autopsy perform 1 \sum Yes 2	y prior to completion of cause of			
<u>~</u>	an: Th tificate or, pa	a)	25. Was case referred to medical	26. Place of Death (Ch		2 X No 1 Yes 2 No			
ΖĬ	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	To B	examiner? 1 Ves 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Out	patient 3 Other: 4 Nursing	Home 5 🗆 Resider	nce 6 Other (Specify)			
o			27. Manner of Death  Natural 5 Pending  28a. Date of injury (Month, Day, Year) in	jury work?	28d. Describe hov	w injury occurred			
sion		Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No	28f Location (Str	reet and Number or Rural Route Number.			
Division of Vital Records,			4 $\square$ Homicide determined building, etc. (Specify)	m, street, lactory, office	City or Town,				
		Medical	29a. Certifier  1   Certifying Physician: To the best of my knowledge, c (Check 2   Medical Examiner: On the basis of examination and/or	leath occured at the time, date and place,	and due to the caus	se(s) and manner as stated.			
	the H hin 24 the F	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowle	edge, death occurred at the time, date and p	lace, and due to the	cause(s) and manner as stated.			
	<b>6</b> ½ 6 <u>8</u>		29b. Signature and title of certifier	29c. License number 52326		9d. Date signed (Month, Day, Year)			
	,		30. Name and address of person who completed cause of death (Item 23a) (T			February 9, 2010			
	5		James K. Lightfoot, MD 7600	Carroll Ave., Takon	na Park, 1	MD 20912			
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  32. Registrar's Signature  33. Date filed (Month, Day, Year)									
	Registra	16		17					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 7, 2010 **Physician** Catherine M. Bauer 10:49 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1345 Dalton Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) August 12, 1956 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 □ **x**F 53 Mary Land 214-70-8297 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore Baltimore Maryland 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 1345 Dalton Road 21234 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Should be filed within 72 and Mental Hygiene.
s marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) H & R Block Certified Advanced Instructor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving Russell Bauer Barbara Popp ဂ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Hasselbarth/Mother 1904 Larch Court Edgewood, Maryland 21040 27 Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' permit. Pages
Department of
Important: If It
any injury or o 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Moreland Memorial Park 2/13/10 Baltimore Maryland 22 Name and Address of Facility Leoannd J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Arterio sclera COURSCH (a)> disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an has autopsy performed? Yes 2 No After this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Nesidence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation s after de. "al Director: Atte Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 and manner stated.

State Registrar

2001

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DHMH 17 Rev 1/2001

29b. Signature

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

MD

\$2. Registrar's Signature

ble

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ann Taveau Burroughs 1:25 February AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 410 Brightwood Club Drive Baltimore Lutherville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F (Month, Day, Ye Hours Min. Director 219-22-7244 87 Marvland Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 🔀 No Lutherville 10e, Street and Number 10f. Zip Code ò 10g, Citizen of What Country? Funeral 23a 410 Brightwood Club Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. \$ 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 years Financial <u>Investor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harrington Burroughs Nannie Taveau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dare Hartwell (cousin) 3215 Scott Place NW Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery! 2-20-10 Baltimore, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland

23a. Part 1. Deer the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) 21. Signature of Funeral Service Licensee Interval Between Onset and Deat Immediate Cause (Final Physician/ NOUSTIVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No ☐ Yes 2 🗓 1 Tes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 4 Nursing Home 27. Manner of ath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No Investigation Accident 1 L Yes Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Hospital 6 24 hours a 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Guntifying Numar Proprieture: It this cost of my knownedge, death continued at the time, date 2 nd place, and due to the cause(s) and manner as estated. To the I within 2 To the I ature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Box 68760

Division of Vital Records.

DHMH 17 Rev 7/2009

MANUEL 31. Date filed (Month, Day, Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 6. 2010 DOROTHY M. BOSSOM 7:40 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SPRINGWELL SENIOR LIVING BALTIMORE CITY N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours 5/10/1912 **Director** 217-12-3976 MARYLAND Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE CITY 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 ROLAND AVENUE 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) WYMAN PARK BAKN Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY 12TH GRADE Be 17. Father's Name (First, Middle, Last) th and Mental F 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ELLEN TROUP WILLIAM HOLLIFIELD traumatic and 2 should be Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1524 PICKETT ROAD LUTHERVILLE, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr. WILLIAM HOLLIFIELD/NEPHEW 21093 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY. INC. 2/8/2010 CATONSVILLE, MD 21. Signat re of Funeral Service Licensee MO1139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL CHRONIC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pendina work 1 Yes 2 No Accident Investigation 24 hours after deatl Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) Name and address of person who completed cause of death (Item 23a) (Type, Print) ROGERS AVE-BALTIMORE MD BURI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10th 3. Time of Death Physician/ 2010 Joseph Dean Brackely, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death -1-en かかん unni **Baltimore Washington Medical Center** . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours (Month, Day, Year) Director NY 127-03-0373 Aug 24, 1921 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 135 Steeplechase Circle 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 10/12/194 Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 12/16/194 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Casket Builder Boyertown Casket Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joseph E. Brackley Elizabeth Hogan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Brackley Son 135 Steeplechase Circle Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 15, 2010 Glen Burnie, MD Atlantic Crematory, LLc 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to for as a conseque Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform ☐ Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tyes 2 No ျ 1 Npatient 2 ER/Outpatient 3 DOA 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) After this 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗷 🖵 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) d title of certifie 29d. Date signed (Month, Day, Year) V 2010 rsón who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 180 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Marie Buchanan Jebruary 20/0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Danake t0S If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 □ M 2 □ Months Days Hours Min 236 24 1003 April 26,1923 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 827 Dorsey Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑XNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3√2 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmetics Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Whitaker Martha Α. Prader 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger O. Buchanan (son) 26648 Tintop School Road Mechanicsville, Md 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Feb 12, 2010 Baltimore Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Siunal Service Licens 1407 Old Eastern Avenue Essex Maryland 21221 23a. Fart 1. Enter the disease, or, should be Approximate Interval Between Onset and Death not enter the mode of dving, such as cardiac or respiratory arrest. aused the d omplications th Due to (or as a consequence of) AOV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? and Checia 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No No 6 ☐ Other (Specify) njury occurred

**Examiner** Box 68760. P.0. of Vital Records.

The law requires that the death certificate be executed burial-trar physician s the burial attending p for use as t signed by the a funeral director, Division or Attending death. within 24 hours after deatl To the Funeral Director; filled in by the Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

Examine

Physician/Medical

of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once.

**Physician** /Medical

the Maryland

death with

Pe	FIGURE STATE	1 L Yes 2 L	TIL Yes 214 No 3 Probably 4 Onk					
e Completed	Acute Hypox	24a. Was an autopsy performed? 1 □ Yes 2 ▼ No	24b. Were autopsy findings ava prior to completion of caus death? 1 □ Yes 2 □ No					
		26. Place of Death (Check only one)						
T B		Hospital: 1  Inpatient 2  ER/Outpatient 3	DOA Other: 4 Nursing He	ome 5 ☐ Residence 6	Other (Specify)			
		28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred			
Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factoriding, etc. (Specify)	ctory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number			
	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.							
	29b. Signature and title of certifier	29c. License number		29d. Date	e signed (Month, Day, Year)			
		VI_	·	3 /	01:0			

no completed cause of death (Item 23a) (Type, Print)

9000 Frank

Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florence February Brock To. 2016 10:10PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14013 Jarrettsville Pike Jacksonville Baltimore Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-28-1102 1 🗆 M 2 🗶 F Days Hours June 8, Director 80 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Funeral Director 10d. Inside City Limits MD Baltimore Jacksonville 1 ☐ Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14013 Jarrettsville Pike 21131 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White Specify 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Food Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Not Known Not Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Brock / Son 101 Yorkleigh Road Towson, Maryland 21204 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2/16/2010 Timonium, Maryland 4 Donation 5 Other (Specify) Dulaney Valley Mem. Signature of Euroral Service Licenses 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Medical Onset and Death disease or condition resulting in death) Myocarria CUTE Due to (or as a consequence of) Examiner Sequentially list conditions, Examine It any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence oil the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 ed by the a detached f 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy **Director:** After this certificate It in by the funeral director, page performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 은 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 Natural iniury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29c. License number 29d. Date signed (Month, Day, Year) 2111 completed cause of death (Item 23a) (Type, Print) 30. Name and address Parkville MD 21234 no Rd Svine E

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

ORIGINAL

2010 Regist

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 00:49 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth April 10, 1966 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🖾 f 242-33-2897 Months Days Hours North 43 Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Takoma Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8120 Lockney Avenue 20912 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Smith

132 Wood Lake Dr., Apt. 123 Athens,

7600 Carroll Ave., Takoma Park, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

20c. Location - City or Town, State

20012

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner

Physician/

Medical

10a, State

Examiner

**Funeral** 

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Director

Funeral

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Completed

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Cecil Stinson

Betria Stinson

19a. Informant's Name/Relationship (Type, Print)

20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State

(Daughter)

with the Maryland

Page 1 and 2 should be filed within 72 hours after death

attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be Medical Certificate:

Division of Vital Records, P.O. Box 68760

	4 Donation 5 Other (Specify)	Coulters Gro	ove Cem.	2-6-10	Newto	on, NC					
	21. Signature of Juneral Service Lice se	<sup>2</sup> A 1 1 1 6 2 5	and Address of Facil East D St	Ty Funeral ., Newton,	Home NC 28	602					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☑ Unknown  23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t	23	3d. Date of deli	very Day Year							
	Part II. Other significant conditions contributing to death but	not resulting in the underlyi	ng cause given in Par				the cause of death?				
1				a	Vas an utopsy erformed? Ves 2 🐼 No	prior to codeath?	opsy findings available ompletion of cause of				
	25. Was case referred to medical		26. Place of De	ath (Check only one)							
	examiner?  1  Yes 2 No Hospital:  1 No Inpatien	t 2 ER/Outpatient 3	DOA Other:	Nursing Home 5 🗆 F	esidence 6	Other (Specif	fv)				
	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐	28d. Descri	pe how injury o		<i>y</i>				
	4 Homicide determined 28e. Place of Injury building, etc. (	- At home, farm, street, fac Specify)	tory, office		n (Street and f Town, State)	Number or Rura	al Route Number,				
	29a. Certifier (Check only one) 1 ♣ Certifying Physician: To the best of more consistent of the control of the	mination and/or investigation,	in my opinion, death of	occurred at the time, da	ite and place, a	nd due to the ca	ause(s) and manner stated.				
	29b. Signature and title of sertifier		29c. License number		29d. Date	signed (Month,	Day, Year)				

20b. Place of Disposition (Name of

cemetery, crematory or other place)

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Padma Chirumamilla, M.D.

FEB12

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 11:40AM FLWOODD CAHOON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimure If Under 1 Year If Under 24 Hrs 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 XM 2 - F Months Davs Hours (Month, Day, Year, 89 Director 220-05-2173 1920 Tune Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** Baltimore MD 1 ¥ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Number USA 23a 21229 1205 Elmridge Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armeu 1 XYes Black, White, etc. o. I Xyes 2 NUS Army If Yes, Give 2/61942 Year or Dates, 1113 3/1045 þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced "natural" Completed the Medical Decedent's Education ecedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Bakery Transportation Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Mae Combs Henry W. Cahoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1205 Elmridge Avenue, Baltimore, MD 21229 Frances H. Cahoon/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remetery, crematory or other place)
Final Journey Crem. 1 Burial 2X Cremation 3 Removal from State 2/12/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Dorrota Marshall Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 1 Ma 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line terval Between Onset and Death Immediate Cause (Final Sens, s Physician/ disease or condition resulting in death) DMINE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immedicause. Enter Underlying Intrabal Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No r this certificate hard 2 No ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No Other: မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina within 24 hours after deam.

To the Funeral Director: Aft 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

L19756

street

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:55 A M Zula Feb 5, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 719 Maiden Choice Lane HR402 Catonsville **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🗹 F 80 Director Duisiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examinating Institute 2. Director MD **Baltimore** 1 ☐ Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR402 21228 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator 5+ Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert F. Abington Alna Early 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Dodson Daughter 103 Red Oak Dr. Lincoln University, PA 19352 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 15, 2010 Atlantic Crematory, LLc Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Furieral & rvine Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ PIMER 2₽No 3☐ Probably 4☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ∐ Yes Division of Vital 2 No 1 □Yes 2 □No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1∐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☑ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of

Date filed (Month.

Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

1)0039297

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03400 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 8, 2010 Physician/ Delbert Colvin 5:40 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Months Hours Min. 01/29/1933 176-24-9442 Director Pennsylvania Usual Residence of Decedent Department of Health and Mental Hygiene, Important, or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once. 10b. County 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1318 1st Road 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes. Give Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Trucking Be 17. Father's Name (First, Middle, Last, I and 2 should be filed I Health and Mental H Item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Colvin Hallie Maiee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faith Moucheron (Step-Daughter) 1318 1st Road, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 02/12/2010 Baltimore, Maryland 22. Name and Address of Facility Ski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee BrūždŽIňski Funeral
1407 old Eastern Avenue, Es

20a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition reviting in death)

a. CONCESTIVE HEART FAILURE Approximate Interval Between Onset and Death Enysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): e attending physician and for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy P.O. Box in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 X No 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 🗶 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and ti 29c. License number 29d. Date signed (Month. Day, Year) 2 20/0 berson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

30. Name and address<sup>l</sup>d

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 02709/2010 Ellsworth Noe1 Diver 05:00pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Baltimore Baltimore 8. Date of Birth (Month, Day, Yea 12/25/1918 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min 218-01-3057 Director 91 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, I'm Madical Examination is stated in the Anglore. 10c. City. Town or Location 10a. State 10d. Inside City Limits 1 ¥Yes 2 □ No Director N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2508 Ailsa Avenue U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 \(\sumsymbol{Q}\) Yes 2 \(\sumsymbol{Q}\) No

If Yes, Give
Year or Dates \(\frac{1}{2}\) 942-46 Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. ð Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Engineer 6 Baltimore Co. Hwy. Division 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harrison Morton Diver, Sr. ၉ Mary Wickman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Jackson Diver, Nephew 5817 Meadowood Road, Baltimore, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Oak Lawn Cemetery 02/15/2010 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J.Ruck, Inc. 5305 Harford Road, Baltimroe, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** terial disease or condition resulting in death) DINOMOUNIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Cuter or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown signed by the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Demento 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate Diabetes 1 ☐ Yes 1 ☐ Yes 2 ☐ No of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 h (Check only one) 29b. Signature and title of certifier 05864 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boulevaso Walther 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Barbara Carol Dasch 9:30 AM <u>February</u> 2010 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford ARC of Northern Chesapeake Aberdeen | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Bept. 21 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1 M 2 X F 1943 212-92-2481 66 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If lem 27 is marked other than "natural" or home any injury or other traumatic 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Completed by Funeral Director 1 ☐ Yes 2 🖾 No Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 711 Courtney Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Garrett Dasch Louise Lamson ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 41091 Elmer Dasch Brother 10674 Aspen Place; Union, KY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Woodlawn, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Guneral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part 1. Enter the disease, or o implications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demonta **Physician** /Medical Due to (or as a consequence of): Examiner distrola Sequentially list conditions, it a y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last He to for as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Dheummi'L Due to (or as a consequence of): P.O. Box 68760. Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 **4**No 1 ☐ Yes 2 🕒 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only op Other: 4 Nursing Home 1 Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

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1 - State Amend Items 25,23aPtII per me,2901,03/03/2010dhb

Certificate of Death

Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month <u>Matilda Evans</u> 31, 2010 Medical lan 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4042 White Star Way Ellicott City **Howard** 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 1 □ M 2 🛛 F Months Days Hours Min (Month, Day, Year) Director Yrs. 209-10-3472 Feb 3, 1917 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XNo MD Howard **Ellicott City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4042 White Star Way 21043 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ANO Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Hairdresser Beautician** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Saleeba Sadie Abraham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Kalin Daughter 4042 White Star Way Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 10 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Feb 05, 2010 Johnstown, PA **Grandview Cemetery** Signature of Funeral en Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ormet and Death Priysician/ hydratio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 Di ISEQI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Alzheiner Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed TATION APPROVED BY MEDICAL EXAMINER sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical CERTIF Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ō Day Pregnant at time of death signed by the at d be detached fo Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Tacture (pathologic) autopsy performed? Yes 2 No certificate 28 C 2 🗌 No 1 Yes B B 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Sp After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director, of completed filled in by the incompleted filled in the incompleted filled filled in the incompleted fill 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, tonic 1)007636

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State Registrar Stevens

Funt

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21076

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6320

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh e901 3/1/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Regis Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RRAINE OSBRINK Month ZOI D 023; M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TATE HOUSE HOSPICE OF THE CHESAPEAKE LINTHICUM ANNE ARUNDEL Social Security Number If Under 1 Year If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Year) 1925 1 □ M 2 🗷 F Months Days Hours Min. Director MARYLAND 216-20-0533 Usual Residence of Decedent shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 □ No MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 769 S. WOODINGTON AVENUE 21229 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ HOMEMAKER 12TH GRADE OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VERNON G. LIVINGSTON ROSINA M. DILLMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES E. FOSBRINK/HUSBAND 769 S. WCODINGTON ROAD BALTIMORE, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
MOST HOLY REDEEMER 1 Nurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/15/2010 BALTIMORE, MD CEMETERY And Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. be c 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy performed' this certificate 2 [ 1 Yes Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ပ္ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I funeral 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death.

Funeral Director: A Accident 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of # npleted cause of death (Item 23a) (Type, Print) lichaa w FENSE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.															
			For State		State of M	arylan		oartmer e <i>rtificat</i>			and N	/lental Hy	•	20	10	031	+05
			Registrar  1. Decedent's Name (First, M	liddle, Last)			C	eruncau	9 01 L	Jeam		2. Date of De	Reg. N	o. <u>C</u> U	IU	3. Time of I	
	Physicia Medi		Robert	F.	Fasy							Month Febru	ary	ay 10,	Year 2010		
4	Examir	ner	4a. Facility Name (if not institu Sella Mari	s Hos	pice				Time	r Location Onium	l		4	c. County Bal	of Death . <b>timo</b>	re	
	Funeral Director		5. Social Security Number 162–48–1866		7. Ag	e (In yrs. Ia	ast birthday Yrs.	) If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Da NOV 2	ay, Year)	1959	g. Birth Cour	place (State or atry) PA	Foreign
	yland f show ed at	햝	Usual Residence of Decedent  10a. State 10b. Con		ord	10c. City	y, Town or I		. d	e Gra	<i>a</i>					10d. Inside City	
100	ne Mar or 28a- notifii	Dire	10e. Street and Number		<u> </u>			10f, Zip		e Gra	.ce		10 0	itizen of V	/hh-On	1 🔀 Yes	2 🗌 No
MILLO	with the second	Funeral Director	100 Revolution Street, Apt. 401 21078 USA										itry r				
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 Never Married 2X Married 1 Yes 2 XNo										k, White,	can Indian, etc. hite				
15-0	72 hou n "natu fedica	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16b. Kind of E									Kind of Bu	siness In	dustry			
212	within giene.												d				
land	d be filed Jental Hy Irked oth	To Be	17. Father's Name (First, Midd Harry J.		У					18. Moth	er's Name Glor	ia Bu	Maiden Irgei		)		
CZ   C   C   C   C   Baltimore, Maryland 21215-0036	nd 2 should ealth and N n 27 is me ier trauma		19a. Informant's Name/Relati				19b. Mai	ling Address 0 Fanr	(Street a	and Numb Orive	er or Rura • Ar	Route Number	er, City o	r Town, Si	tate, Zip ( <b>01</b>	Code)	
timore	Page 1 al Iment of H tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremate 4 ☐ Donation 5 ☐ Oth		Removal from State	C	emetery, cri al Jo	oosition (Nan ematory or o urney	crer Crer	n.	2/12,	) 2010	Wo	odbi	-	own, State	
Bali	permit Depari Impor any in		21. Signature of Funeral Serv	ice/Dicense	Dorota I	Marsh	all	22. Name an <b>N</b> E	d Addres lary O Bo	s of Facili Land ox 14	Črema 13. I	ation S Baltimo	ervi re,	ices MD 2	1203		
	Physician/ Medical Examiner		23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	e, or compli ist only one	cations that caused cause on each line.  Due to (or as	MG	EL	LIVEL		g, such as $2656$		_	rest,			Approximate Interval Betw Onset and De	/een
E 25 09		dical Examiner	Sequentially list conditions, if any, leading to hume-list cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last		Due to (or as:												
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23	Bc. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	☐ Ectopic p	ecify)	у				23d. Date Mor		ery Day Ye	ar
%. 0.4	s that the gned by be detained	by	Part II. Other significant con	<b>dition</b> s con	tributing to death b	ut not resu	ulting in the	underlying o	ause giv	en in Part	l.					ne cause of dea	
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Sion	tendin death. tor: Aft the fur	Certificate:		nding estigation uld not be			injury	М		Yes 2 🗆	No						
RC DC Division	ital or At urs after or ral Directiled in by			ermined	28e. Place of Inju building, etc	ry - At hor :. (Specify)	ne, farm, st	reet, factory	office		2	28f. Location (5 City or Tou			or Rural	Route Number	τ,
	the Hosp nin 24 ho the Fune npleted fi	Medical	(Check 2 Medic only one) 3 Certify	al Examine ying Nurse	ian: To the best of r: On the basis of ex Practioner: To the	kamination	and/or inve	stigation, in n	ny opinio	n, death or	ccurred at	the time, date a	ind place	, and due	to the cau	ise(s) and mann	ner stated.
	With Cor.		29b. Signature and the of con	tifier IQQ (	ANP			29c.	License	number	2		29d. Da	te signed	(Month, E		
	A		30. Name and address of pers	son who con	npleted cause of de	eath (Item :	23a) (Type,	Print) //AC	LEY	, Ri)	TI	MONIU	M,	MD	21	.093	
1 21	Stat Registra	_	31. Date filed (Month, Day, Yea	EB 1	2 201 (Pregistre	Signatu	w p	Ha	Coop				,				

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			1 - For State Registrar	State of Marylan		rtment of Heal ctificate of Dea			ene . No. 2011	0 0 3 4 0 6
	Physic		1. Decedent's Name (First, Middle, Las	GNAUE	S		2.	Date of Death	Day Year	3. Time of Death
E.J.	/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Town, or Locat	tion of Death		4c. County of Dea	ath / p/
-			Seasons Hospice  5. Social Security Number 6. S	7 4 //-	to a things of	Randalls	Stown nder 24 Hrs.   8.		Paltin	
	Funeral Director	2	25-50-4139	ex	Yrs.	Months Days Hou	urs Min. 8.	Date of Birth (Month, Day, Y	(ear) 9. Bi	rthplace (State or Foreign country) VA
	yland Iow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	e Mar 3a-f st	ctor	MD Haltin	noire	Gwyni	n Oak				1 □ Yes 2 □ No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	heath v	eral	2002 Woodlawn drive,	Apt. B1 12. Was Decedent Ever in U.	S 13 V	21207 Vas Decedent of Hispanio	c Origin? (Specify	Vas or No-	ISA 14. Race - Am	orican Indian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1	1	Yes, specify Cuban, Mer	xican, Puerto Rica	an, etc.)	Black, Whi	
15-0	72 hc	letec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	ent's Usual Occupation kind of work done during	most of working		b. Kind of Business	
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nd	e filed al Hyg f other vent,	BeC	17. Father's Name (First, Middle, Last)		1	fice Supply	lother's Name (Fi			- Culty
yla	ould by Ment	2	John David Goodwin				Virginia			
	nd 2 sl alth an 27 is r r traur	r	19a. Informant's Name/Relationship (7 Patricia Williams/ fr		1	g Address (Street and Nu Kincheloe Aven				Zip Code)
altimore,	es 1 au of Hea fitern rothe		20a. Method of Disposition	20b. P		sition (Name of atory or other place)	Date		c. Location - City o	Town, State
ţ	t. Pag tment tant: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	) New	Cathedr	al Cemetery	02-16-20	010 B	altimore, M	D
Ba	permi Depar Impor any ir	0	21. Signature of Funeral Service Licens	1. Wellie	92	Name and Address of Fa	id, Randaili	Funeral I stown, M	tome P.A. o 21133	f Balto. Co.
		3 13	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the death one cause on each line.	n. Do not ente	er the mode of dying, such	h as cardiac or re	spiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		(disease or condition resulting in death)	a. Due to (or as a collegu	uence of):	ences				
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١.	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlyin Cause (Disease or mury	Due to (or as a consequ	uence of):					
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68760,	ficate be executed physician and s the burial-transit	edical		d			<u> </u>	<del> </del>		
Box	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	alivery
o.	The law requires that the death certi tte has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
S, D.	res that signed b be deta	by Ph	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the un	derlying cause given in Pa	art I.	23e. Did tobac	co use contribute t	o the cause of death?
ord	w require been si should t							1 🗆 Yes	2 □ No 3 □ F	robably 4 Onknown
al Record	ilcian: The law certificate has b ector, page 2 sl	Completed						24a. Was an autopsy performed 1 ☐ Yes	prior to death?	utopsy findings available completion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	ED/Outrations	Othor	lace of Death (Cf		No	> peco
	iding Physician: th. : After this certifica ! funeral director, p	$\vdash$	27. Manner of Death 1 Natural 5 ☐ Pending	1 ☐ Inpatient 2 ☐ I  28a. Date of Injury (Month, Day Mar)	28b. Time of Injury	28c. Injury at Work?	Nursing Home 28d.	Describe how i		ecify) -
Division	Attending r death. sctor: After by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be	WIH		M 1 □Yes 2				
2	tal or A s after al Direct ed in by	Certif	4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, stre	et, factory, office	28f. I	Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical (	29a. Certifier (Check only one) 1 Certifying Phy 2  Medical Exami	sician: To the best of my know ner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time, datestigation, in my opinion,	te and place, and death occurred a	due to the caus t the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	Verith Constitution	Σ	29b. Signature and little of certifier	Son	no	29c. License numb	72	29d.	Date signed (Mon.	
	11		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	0035	Some	MA	up 2	2010 1209
ļ.	Stat Registra		31. Date filed (Month, Day, Year) FEB 1 2 2010	32. Registrar's Signati	ure					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03407 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month February 10 a M 2010 Nancy Kirby Gillett /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** 4c. County of Death maryland Greneral 5. Social Security Number (In yrs. last birthday) Year If Under 24 Hrs. 7. Age Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min Director 85 283-24-8019 18, 1924 Pennsylvania Sept. Usual Residence of Decedent the Maryland 10a. State 10b. County in than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 TYYes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Penhurst Avenue 21215 by Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maréland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permt. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ragny i jury or other traumant event, the Theology. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Gillett ပ Mary Simon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian P. Carpenter (Sister) 1300 Shorewinds Ln., Vero Beach, FL 32963 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory 2/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signal of Funeral Service Licenses 22. Name and Address of Facility Cox-Gifford-Seawinds Funeral Home & Crematory 10 1950 20th Street, Vero Beach, FL 32960 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 

A Company of the condition resulting in death) Approximate Interval Between Onset and Death **Physician** /Medical - ue to (o as a cons ruence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) certificate be executed and burial-trar Du (or as a consequence of) Box 68760 attending physician Physician/Medical as the IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 1 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.O. the 9 Unknown þ signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 s 24a. Was an autopsy performed? Yes 2 2 No certificate Division of Vital 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Tes 2 Livio မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pleath.
within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of After 1 Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar

LHOUSE OFFICER

32. Reginar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print Man WISh II/485, M.D. 90 M

Year)

29d. Date signed (Month, Day, Year)

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~	Funeral Director		5. Social Security N		6. Sex	M 2 ₹ F	7. Age	e (In yrs. 18 87	ast birthda Yrs	Me	Under 1 Year onths Days	If Und Hours	ler 24 Hrs. Min.	8. Date of Bi	rth		9. Birtho	lace (State or Fording)	e <i>ig</i> n
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200	the Maryland or 28a-f sho e notified at	Director	Mary Land	,	/A			10c. Cit	y, Town or	Locatio L <b>tim</b> e							1	0d. Inside City Lin 1 🙀 Yes 2 □	
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Sion	Attenc r death ctor: /	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investig 6 Could n determine	not be	28e. Place	of Injun	y - At hon	ne, farm, s	M street, fa	ctory, office	Yes 2	_	8f. Location (S	troot a	ad Number	or Pural B	louto Number	_
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	State Registra	_	31. Date filed (Month,	FEB 1	2 201	\$2. Re	strar'	s Signatu	re A	Bo	res)	100	1166	1103		<i></i>	(11)0	· (VIII) E)	<del>7</del>
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Nellie Grubuski February 8,2010 7:05P /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Rock Spring Village 5. Social Security Number 6. Sex Forest Hill 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours 90 216-05-4868 March 18,1919 MAryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4749 Chatford Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna M. Schmacke <u>William Haller</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2215 Pelham Avenue Balto.Md. Janet A. Colman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-15-2010 Parkville, Md. Parkwood 21. Signature of Fine Service 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardio my Pathy Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cercbrovascular accident Recurrent Deep veraus thrombosis. Dementia 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 1 Be Certification: To

Examiner burial-transi Division of Vital Records, P.O. Box 68760, the for use þ signed t page 2 should Hospital or Attending Physician; The

After t n 24 hours after death.

• Funeral Director: A pletely filled in by the fu Medical

**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f shorevent, it is the ficel Exa. of the Light by notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any lipiny or other traumatic event ODE.

**Physician** /Medical

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

Alzheim	er type.	- anemia of	chronic i	(Inen.	24a. Was an autopsy performed? 1 □ Yes 2 ₩ No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No								
25. Was case refer examiner?	red to medical		26. Place of Death (Check only one)											
1 ☐ Yes 2 🔀	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Home 5 ☐ Residence 6	ome 5 Residence 6 Sother (Specify) Assisted Livin									
27. Manner of Deat  1  Natural  2  Accident	5 ☐ Pending investigation		28b. Time of Injury M	c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury									
3 Suicide 4 Homicide	6 Could not be determined		ome, farm, street, factory, o fy)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one)	1 ☑ Certifying Ph 2 ☐ Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred a ation and/or investigation, i	t the time, date and place n my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)								

29c. License number

29d. Date signed (Manth, Day, Year) 09/10

the

2

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scite 263 Forest Hill MD21050

31. Date filed (Month, Day, Year) FEB 1 2 2010

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Graf George A. 2010 Year February 6:40 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 190-32-7453 74 Director Yrs. Hungary July 22, 1939 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Harwood MD 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 20776 4748 A Flanders Lane within 72 hours after death with 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. ed other than "natural", event, the Medical Exa 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Optician Health Care 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F is marked o ည unknown unknown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4748 A Flanders Lane, Harwood, MD 20776 Page 1 and 2 sl ment of Health a tant: If item 27 is Karin S. Graf / Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 1 Burial 2 X Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2/13/2010 Woodbine, MD Final Journey Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licenser Dorota Marshall Moushork 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line immediate Cause (Final THEUMODIA Physician Medical resulting in death) Due to (or as a consequence of): Examiner KENAL TAILURG FIVE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) KESZIRATURY Cause (Disease or iiniury sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical CORON ANT 154ASE or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? þ MELLITUS DIABETES Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 2128456 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed' death? certificate 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ည 1 M Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 M Natural 1 Tes 2 Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

TAKOMA PARIC MD

7600 CHANOL AVA

MM

31. Date filed (Month, Day, Year)

Amend #1, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name\_(First, Middle, Last) Barbara F. Gallagher 2. Date of Death 3. Time of Death **Physician** Year /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, fown, or Location of Death **Examiner** 4c. County of Death Columbia **Howard County General Hospital** Howard Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 533-48-147L Usual Residence of Decedent Months 1 M 2 D Days Hours Min. Director Nov 1, 1935 filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination of the confident Director MD Howard 1 ☐Yes 2 No Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10001 Windstrean Dr. Unit 801 Funeral 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 Specify. 3 ☐ Widowed 4 ☐ Divorced NI Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Computer Systems Analyst** Government Pages 1 and 2 should be filed vent of Health and Mental Hygint: If item 27 Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pierpont Fuller ပ Frances Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip J. Gallagher 10001 Windstrean Dr. Unit 801 Columbia, MD 21044 spouse Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) Feb 13, 2010 Columbia Memorial Park Clarksville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City. MD 21043 23a. Part 1. Fyter the dise shock, or more thanks r complications that crused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death List only one cause Immediate Cause (Final **Physician** ulu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CUMONIG Sequentially list conditions, if any Land Linguistic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy 4 ☐ Pregnant at time of death Month Day Vear 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Onknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has 2 **1** No 1 ☐ Yes 1 ☐ Yes 2 100 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4No this ٩ 1 4 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State FEB 1 2 2010

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Bruce Gilbert Gerry  $P^{M}$ 6, February 2010 7:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 425 Riverside Drive Baltimore Essex 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**☑** M 2□ F Months Days Hours 62 214 44 0296 April 2,1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 ☐ Yes 2 🙀 No Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 425 Riverside Drive 21221 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Myes 2 No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Gerry Genevieve Kirkendall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Gerry (Wife) 425 Riverside Drive Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 2/10/2010 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastones LIVER disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

/Medical Examiner requires that the death certificate be executed burial-Division of Vital Records, P.O. Box 68760 attending p sign be page 2 Hospital or Attending Physician: The

**Funeral** 

**Director** 

show

?7 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Eventhan and the notified at

"natural", or

72 hours after

12 should be filed w h and Mental Hygie 7 Is marked other tl

permit. Pages 1 and 2 s Department of Health ar Important; If item 27 Is

Physician

P

injury o

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ģ Be Completed Certification: To filled in by the

		1XYes 2 □ No 3 □ Probably 4 □ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 ☒No 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	ne 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death 1  Natural 5  Pending 2  Accident investigation	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, death occurred at the time, date and place, ininer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

29c. License number

124356

24 hours after death Funeral Director:

completely the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Square Dr. Suite ZEOD Baltwore MD 21237 Franklin William 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

29b. Signature and little of certifier

(Walnut)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** Year NES 7 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1**X**M 2□ F Months Days Hours Min South Carolina Director Usual Residence of Decedent 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 XYes 2 □ No STOW more 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: or items, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Ď Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ en 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4hler Department of Health Important: If item 27 any injury or other tronce. 019 00 60 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Immediate Cause (Final Physician leta Sta to disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes ANO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

We

31. Date filed (Month, Day, Year)

FEB 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29a & 30 per nyp g900 2/12/10 TT

State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar 03414 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician February 10 2010 9:09 а.м Manzell Hines Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Raltimore <u>Stella Maris Hospice</u> Timonium 1 Year | If Under Birthplace (State or Foreign Country)
 NT7 24 Hrs. 5. Social Security Number If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Days W 1 ☑ M 2 ☐ F 61 Vrs 7-29-1948 Director 088-40-1680 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified as 1 ☐ Yes 2 No Director Rosedale Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5379 King Arthur Circle 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_\_2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Brice Robert Hines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5379 King Arthur Circle, Rosedale, MD 21237 Tezell Hines/Daughter 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park 2-17-10 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Palto. Co. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death END Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that is listed assets. Due to (or as a consequence of). Examiner sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 1 □Yes 2 DNo 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Souther (Specify) HOS PICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) (Check one) (Check only one) (Check only one) (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed gauss of death (Item 23a) (Type, Print) Jennifer Hauf, CRNP Stella Maris Hospice, Timonium, MD 32. Registrar's Signature State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, Division

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 900 Loch Raven Bowl.

Wicho In M.D.

32. Registrar's Signature

29c. License number 0 4 1 3 6 5

29d. Date signed (Month, Day, Year)

February 6,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** KNVI 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–16–1932 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1 XM 2 F Yrs 232-50-5580 Virginia **Director** West Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 🏻 No Director MD Baltimore Middle River 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö 2112 Coralthron 21220 United States 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give AY Specify: þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years Steelworker Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked c Giles E. Haves Virgie M. McCune ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deborah J. Hayes (Wife) 2112 Coralthron Road Middle River, MD Health tem 27 i 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot
once. # Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2/8/2010 Baltimore, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the arrival future. List only one cause on each line. Dundalk, Maryland Approximate Interval Between Onset and Death Immediate C e (Final **Physician** Due to ( r ) s a consequence of): disease or condition /Medical resulting in death) Examiner or as a consequence of): Sequentially list conditions, any series of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed X Dtic burial-tran Due to (or as a consequence of) Box 68760. physiciar Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the att 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner' Hospital 1 Yes 2 No Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 28a. Date of Injury funeral 27. Manner of Death 1 Natural To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number RES OUU

State Registrar

31. Date filed (Month, Day, Year)

MILLUL

**FEB 12** 

HAMRICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hvoiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1:40 A.M 2010 Robert Gibson Hewitt, Sr. 4 County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1timore Hanes Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours 1 XM 2 ☐ F Davs 215-28-78 May 18,1931 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 21 No MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 416 Westside Blvd. 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Quotations Manager Electric 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ephram Hewitt Elizabeth Schroeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Josephine Hewitt Wife 416 Westside Blvd.; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Onation 5 ☐ Other (Specify) 2/13/2010 Loudon Park Cemetery Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signalure of Funeral Service Lic and 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Pheumonio disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2  $\square$  No 2 - NC 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 28 hours after death. 9 Funeral Director: After this certificate has been signed by the attending physician and burial-trar Division of Vital Records, P.O. Box 68760, the attending physician ned for use as the burial signed by the funeral director,

Examiner Physician/Medical þ Completed Be

**Physician** 

/Medical

Examiner

Director

Funeral

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at appear.

Physician

/Medical Examiner

Maryland

Saltimore,

Certification: To filled in by Medical

completely To the I within 2 To the I Registrar 29a. Certifier

(Check only one)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D56418

29c. License number

29d. Date signed (Month, Day, Year) February

30. Name and address of person who completed cause of deat (Item 23a) (Type, Print)

Caton Ave, Baltimore 900 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Muriel Harrison Feb 10:35 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST AGNES HOSPITAL BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 🕅 F 213-80-3093 Director 97 Dec. 4, 1912 Maryland Usual Residence of Decedent death with the Marylan 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 140 Sanford Avenue Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the "Actical Eventh 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 TNo Specify: ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank J. Deckert 2 Catherine Schwaab 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cavero 333 Kingston Circle; Sykesville, MD 21784 Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Ponation 5 ☐ Other (Specify) Loudon Park Cemetery 2/17/2010 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licen 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease of complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** day ( disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Lua to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiclan for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 1 ☐ Yes 2 ☑ No Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. hours after death uneral Director: / 2 Accident Investigation 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) the To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DURGADHOT ADHIKARI, MID 02/08/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DURGA BHUT ADHIKARI, 900 (aton Avenue, Bainmore, MB 21229) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

YAR RISON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 03419

		1- For State Registrar				Certific	ate of	Death			F	Reg. No	D.			
Physicia		1. Decedent's Nan						,			2. Date of Dea	ath			3. Time of De	eath
Medical Exami	ner	Jeffrey	W. Hur	mme1							Month February	Day 4, 20		ır	1014 hr	S
		4a. Facility Name 14433 Jarre		on, give street and	number)		4	b. City, Town, Jacksonv		of Death	-		tc. County of Baltimor		nty	
Funeral		5. Social Security	Number	6. Sex	7. Age (	In yrs. last bir	thday)	If Under 1 Y	ear If Un	der 24Hrs.	8. Date of Bi	rth(MN	th(MM/DD/YYYY) 9. Birthplace (State or			or
Director		141-40-33		1 X M 2 F		63	Yrs.	Months D	ays Hou	rs Min.	Sept	6,	1946	Foreigi Cou	n untry) Nev	v York
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Director							10f. Zip Code			1	-	itizen of Wh	nat Coun	try?	
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5-003 ed within tygiene other th	ě	17. Father's Name	(First Middle		<u> </u>				18 Mothe	er's Name (	First, Middle,	Maide	n Surname)			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be		am F. I							ace M		marao	n oumano,			
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nore, MD 21215-0036 siges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the <u>Medical Examiner</u> .				n 3 Removal	from State		ory or othe		wn.	2/0/	2010	<b>Т</b>	owcon	М-	aryland	,
Baltimore, permit. Pages I an Department of Hea Important: If iter	- 1	4 Donation 5 Other Specify: Hilltop Serv. Corp. 2/8/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tours on														
Baltimore, ML permit. Pages 1 and 2 s Department of Health an Important: If item 27 injury or other trauma	Į	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Towson, Maryland 2120 Ruck Towson Funeral Home, Inc. 1050 You										.204 Jork Ro	nad .			
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Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be executed hours after death.  The law requires that the death certificate be seen signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transit.	n/Medical	XUNPENDED		<u> </u>												
50, te be ex tysician	<u>g</u>	IF FEMALE:		23c If yes	3a,27	,28a-f	, per	ME G9	02 4/	27/10	TT	100	3d. Date of	dolivos		
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Vital F hysician: this certifi	a	examiner?	2 No	Hospital: 1	Inpatient	2 ER/OL	utpatient		1011		Home 5	Resid	ence 6	Other:	Scene	
Division of Vital Records, ra or Attending Physician: The law requirers after death.  Solution of the this certificate has been sited in by the funeral director, page 2 should be a but by the funeral director, page 2 should be a second or second	읽	27. Manner of Deat		28a. Dat	e of Injury	28b. 1	Time of Inju	-	ury at Wor	k? 2	8d. Describe	how in	iury occurre	 ed		
ndin ath.	흲	1 Natural	5 Pend	ding	h, Day,Year)	l .	10.05	1	Yes 2X	NO	typica					el
ivisior or Attend after death Director:	<u>[8</u>	2X Accident		28e Pla	/4/10 ce of Injury		10:05 rm. street.	factory, office	building, e		repara 8f. Location (					ber City
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		1/1 /	190	2. 4 h. 11	110			0.0	.M.E.			l	oruary 5,			
	ŀ	30 Name and addr	MI V	who completed as	ISP of door	h (Item 22a)										
j		Pamela E.	. /			i (item 23a) I Examinei	r 111	Penn Stree	et, Baltin	nore. Mr	21201					
Sta	ite	31. Date filed (Mont			egistrar's S				,	_, , , , ,			_			
Regist			FR 12		neur	, A.	par	Las								i

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ıryland	-	artment tificate			and M		giene Reg. No.	UIU	03420
	Physici /Medio Examin	al	4a. Fecility Name (If not institution, give	re street and nymber)	- J		4b. City, 1	11.	Location o	of Death	2. Date of De Month	1 4 Day	/2010 County of Dear	3. Time of Death
	Funeral Director		5. Social Security Number 216-56-5263	igh Kenow C	entel (In yrs. las	t birthday) Yrs.	If Under Months		If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da 8 / 23 / 4	th ly, Year) 17	9. Bird	hplace (State or Foreign ountry) MD
	he Maryland 8e-f show	ector	Usuel Residence of Decedent  10a. State  MD  N/A			Town or Lo	i more					10a Cit	izen of What Co	10d. Inside City Limits  P☐ Yes 2☐ No
	ath with t s 23e or 2 nust be n	Funeral Director	539 S. Fulton		Superior (1.0)	40.1	21	1223		ais 2 (Spo	eifu Vos er No	US		
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic svent, the Medical Evaluation that I will be indiffied at once.	۾	11. Marital Status  1  Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo		1□Yes 2	2[₹No	Specify:	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)		Black, Whit Africa Specify: Amen	<sub>e, etc.</sub> an cican
Maryland 21215-0036	ed within 72 h giene. sr then "nate t, the wedica	Completed	15. Decadent's E (Specify only highest gr Elementary/Secondary (0-12) 12th	ade completed) College (1-4or 5		Labo	dent's Usua kind of wor DO NOT us OTET	Il Occupa ik done d se retired,	luring most			Con	ind of Business	•
/land	2 should be filed within and Mental Hygiene. is marked other then eumatic svent, the Ma	To Be (	17. Father's Name (First, Middle, Last Allen Hutchins								(First, Middle Pumphe		Sumame)	
	1 and 2 should Health and Men am 27 is marke thar treumatic:		James Black/Br								Balt.,		21223	Zip Code)
Baltimore,	Pages 1 announce of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Special)				sition (Nam natory or ot cme1		1/	/17,	ate /10		t., MD	Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Fune/al Service Lice	nsea		5 1	Name and	d Addres Bela	s of Facilit	Harı d,Ba	P. C	clos	e F.Sv 1206-5	rs,PA 5105
760,	Physician and // Medical Examiner supernited burian-transit	dicai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused one cause on each ling.  a	a conseque	nce of):	er the mode	e of dying	g, such as	cardiac o	r respiratory a	irrest,	C	Approximate Interval Between Onset and Death  YOUR  Jayonne
P.O. Box 68	Physician: The law requires that the death certifical this certificate has been signed by the attending phraid director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe						23d. Date of de Month	livery Day Year
rds, P	w requires that been signed be should be deta	ξ	Part II. Other significant conditions	ŭ	ut not result	•	, ,	•					use contribute t ☐ No 3 ☐ P	o the cause of death?
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Vita	sician certifi irector	Be	25. Was case referred to medical examiner?	Hospital:	nt 2∏El	R/Outpatier	nt 3 DO	Othe			(Check only		6 ☐Other (Spe	erifu)
Division of Vital	ff fer ne	ation: To	27. Manner of Death  1 DNatural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		8b. Time o		8c. Injury Work	and the last transfer of	No	28d. Describe	how inju	ry occurred	
Divis	tal or Att rs after de al Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not learnined	28e. Place of Injusted	ury - At hom c. (Specify)	ne, farm, sti	eet, factory	r, office		- 1	28f. Location ( City or To			ural Route Number,
	To the Hospital or Attandii within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Medicai	(Check only 2 Medicel Exa	hysicien: To the best miner: On the basis of and manner sta	examination	edge, deat on and/or in	vestigation,	, in my op	pinion, dea	th occurre	and due to the ed at the time,	, date an	d place, and du	e to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	Q,			29c		e number				te signed (Mon	th, Day, Year)
			30. Name and address of person who	completed cause of d	eath /Item *	3a) /Tune	Print\	91	720	12.			2-14/1	0
			SATPAL S. DANG	M.D. 1015	T. HE	LENA		= E	BALIT	IMO	RE	MD.	212	2.2
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ге	er Alas							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#7&8 per FH G900 2/17/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TRICIA 1939 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel <u>Anne Arundel Medical Center</u> Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **1934** 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 📈 F Months Hours Min Dec 25 Director 76 Mary Tand 220-30-8695 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1391 Rainbow Drive 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dallas Stevens Catherine Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1039 Sugar Maple Drive Davidsonville, MD 21035 Edwin L. Hawse (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 02/05/10 Pasadena, Maryland Carmel U.M. Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Pasadena, Mountain 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inter al Between O set D In Immediate Cause (Final disease or condition resulting in death) chrom Physician ON Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2 No 8 25. Was case referred to medica 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 02,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEGH WIM ANNAPOLIS MOZIKU MICHAEL ENTA UM ·lay 31. Date filed (Month, Day Y 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1134 AM oover February 2010 /Medical 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Buenie ANNE BAltimore Was 6. Sex Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Year) Days 1 🗆 M 2 🗓 F **Director** Virginia 231-84-1419 May 7. 1955 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Innerially, or items 23a or 28a-f show Important; If then 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is "Modical Examine" man be notified. 1 ☐ Yes 2 No Director Marvland Anne Arundel <u>Glen Burnie</u> 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 849 Nabbs Creek Road 20160 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N /A Shoppers Food Warehouse Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Gibson, Sr. Elizabeth ပ Marjie Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeff C. Hoover (Husband) 849 Nabbs Creek Road Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/08/10 Atlantic Cremation Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 folle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** reek /Medical Due (d (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 TUnknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate **Division of Vital** 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Appatient 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: | d in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 II Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number Drive, Glen Burnie, MD 21061 ompleted cause of death (Item 23a) (Type, Print) Name and address of person 301 Hospita
32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Virginia <u>Henderson</u> /Medical <u>February 7.</u> 2010 1:00 A 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Signature Health Care of Mallard Bay Cambridge Dorchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 Ϊ F Months Days Hours Min. Director 209-28-1568 Nov. 29.1936 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2620 Rebecca Lane by Funeral 21613 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: White Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Homamker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ould be f Pages 1 and 2 should ဂ္ Adolph Sanoske Virginia Mavers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 2620 Rebecca Lane Cambridge, Rebecca A. Buck (Daughter) Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery | 02/15/2010 | Brooklyn Park, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses 23a. Part 1 \_\_nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Concer pancreatic /Medical ue to (or as a consequence of): Examiner hole Cystitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ oritensioi 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate of Vital 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? Atter 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending death. after death Director: A d in by the f investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Hospital or Attending Physician: To the Hospital o within 24 hours aft To the Funeral Di completely filled in

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

ohnson 32. Regis rar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

100 Bramble Cambriage MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Month** Febru Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death timor 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔽 F Months Days Hours Min Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 XYes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) (niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Aicensee Name and Address of Facility Seph L Russ Home 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Due to (or and Examiner Sequentially list conditions, if any, leading to immediate Examiner attending physician and for use as the buriat-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 this certificate 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျှ 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After сотрые filled in by the funer 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 391 Z

State Registrar

DHMH 17 Rev 7/2009

N

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HMEI

31. Date filed (Month, Day, Year

liam Jackso	n	State of Maryland / Department		Jugiona	10 0010
		1- For State Certificate Registrar		Reg. No.	10 0342
Physic		1. Decedent's Name (First, Middle,Last)	PA-D2	2. Date of Death Month Day Year February 2, 2010	3. Time of Death 1655 hrs
1		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		
		325 Furrow Street	Baltimore	NIF	<del></del>
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours M	· 1	Birthplace (State or eign Country)
		Usual Residence of Decedent	frs.	12 17-171	country) Coc 29 (a
w any		10a. State 10b. County 10c. City, Town or Loc	,		10d. Inside City Limits
yland -f shu t once	햦	10e, Street and Number	10f. Zip Code	10g. Citizen of What Co	1 Yes 2 No
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teelth and Mental Hygiene. tem 27 is marked after than "natural", ur items 23a nr 28a-f shu traumatic event, the Medical Examiner must be notified at once.	Director	325 Furnow St.	21223		SA
with t ms 23a	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (	Specify Yes or No- 14. Race - Amo	erican Indian, Black,
er death nr ite	Funeral	1 Yes 2 No	f Yes, specify Cuban, Mexican, Puer		BLACIC
urs afte tural" amioe	<u>₹</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	Yes 2 No specify:  lent's Usual Occupation (Give kind o	f work done 16b. Kind of Busines	,
O 172 ho no "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	picc	vate.
Z I Z I 3-0030 unld be filed within 7 Mental Hygiene. marked nther than c event, the Medica	Щo	17. Father's Name (First, Middle, Last)	18 Mother's Nan	ne (First, Middle, Maiden Surname)	panels
Inition (e.g., MD 21213-2003) Pages 1 and 2 should be filled within 72 hours nent of Health and Mental Hygiene. Tate: If item 27 is marked in ther than "natur in ruther traumatic event, the Medical Exam	Be C			le a	
hould I nd Mer is mar	70	19a. Informant's Name/Relationship (Type, Print ) 19b. Mail	ing Address (Street and Number of	Rural Route Number, City or Town, Sta	te, Zip Code)
e, MD l and 2 sho Health and item 27 is		Rubert Jackson - brother 214 20a. Method of Disposition 120b. Place of Disp	osition (Name of cemetery,	Balto, md.  Date 20c. Location - City of	2/223
	Ш	crematory or	other place)	•	
Daltimore, permit. Pages l ar Department of Hee Important: If ite injury nr nther tr		4 Donation B Other Specify:  21. Signature Funeral Service Lic see 22	. Name and Address of Facility	-9-2010 Lausd 270 FredHilton 1 F.H. Bacto.	Daso
E B B B A	9,0	Voget A W mil	Pary Pimarch	F.H. Bacto.	m\$12,00
Physician \Medical		23a. Tark Centur the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	r the mos of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic care Due to (or as a consequence of):	diovascular dise	ase	Death
	L	Sequentially list conditions, b			
	nine	if any, leading to immediate  Cause. Enter Underlying Cause (Disease or injury that initiated  C.			
red nsit	Examine	events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transi	dical	d.  X UNPENDED AMENDED 22 27	000 0/17/10 mm		
: <b>68 / 60,</b> certificate be inding physici se as the buri	Med	IF FEMALE: 23c. If yes, outcome of pregnancy	g900 2/17/10 TT	23d. Date of delive	егу
	Physician/Me	Past 12 Horitis?	Fetal death 3 Ectopic pregr	nancy <b>M</b> onth	Day Year
e death the atte	hysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
I RECOTES, P.O. BOX  II The law requires that the death rifficate has been signed by the atte or, page 2 should be detached for 1	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute t	
Aduires	ted			1 Yes 2 No 3 ✔ Pro	autopsy findings available
or Vital Records, ng Physician: The law requir wher this certificate has been sineral director, page 2 should I	Completed		· <u></u>	autopsy prior to performed? death?	completion of cause of
vical Rec ysician: The l his certificate l director, page		25. Was case referred to medical	26.Place of Death (Check	1 Yes 2 No 1 V	Yes 2 No
ysicia his cel direct	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Tour-	ing Home 5 Residence 6 ✔ Oth	er; Scene
After t		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Death		28d. Describe how injury occurred	
DIVISION tal or Attendi rs after death. al Director: A led in by the fu	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, str	1 Yes 2 No	206 Location (Otroph and Number of F	Overel Davida Niverbra. City
ital or irs after in Dir	ertification:	3 Suicide 6 Could not be determined (Specify)	eet, factory, office building, etc.	28f. Location (Street and Number or F or Town, State)	tural Route Number, City
the Hospital or hin 24 hours afte the Funeral Dir	ပ	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occ	curred at the time, date and place, an	d due to the cause(s) and manner as sta	ated.
DIVISION To the Hospital or Attention 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig			
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed <i>(M</i> February 3, 201	
'	1	30. Name and address of person who completed cause of death (Item 23a)	J.O.IVI.E.	replically 5, 201	
Ø	Ų Į		enn Street, Baltimore, MD 2	1201	
S	ate	31. Date filed (Month, Day, Year)  SEED 2010 32. Registrar's gignature	,		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes O. J. O.

			1 - For State Registrar	Otate of W	aryianu / Dep <i>Ce</i>	ertificate of l			erie2 0 1 0	03426
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Death		3. Time of Death
	Physici /Medi		Werner J.	Jackson	n Jr.			Month February	Day Year 07 2010	03:50 P M
200	Examir		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, or	Location of Death		4c. County of Death	1 03.30 F
1			8216 Baltimore &	Annapolis	Blvd.	Pa	asadena		Anne Aru	ndel
	Funeral				e (In yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day,		place (State or Foreign
	Director		216-32-5038	1☑M 2□F	76 Yrs.	Worldis Days	TIOUIS WIIII,	Nov. 08		MD
	w w	]	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L					
	laryla sho	ក			Toc. City, Ibwil of L	ocation			1	10d. Inside City Limits
	he M	Director	Maryland   Anne A	rundel			asadena			1 □Yes 2 ☑ No
	with t	ă	10e. Street and Number	7		10f. Zip Code		100	g. Citizen of What Cour	ntry?
	eath is 23	Funeral	8216 Baltimore &				21122		USA	
	iter d	ä	11. Marital Status  1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Ye's or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	d within 72 hours after death with the Maryland glene. If then "natural", or items 23a or 28a-f show the Medical Exerting must be positived at	b	3 ☐ Widowed 4 ☐ Divorced	1 [x]Yes 2 □ I If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🔀 No	Specify:		Specify: W	White
Õ	2 hou	Completed	15. Decedent's E	ducation	16a. Dece	edent's Usual Occupa	ation	16	6b. Kind of Business/Ind	dustry
215		ble	(Specify only highest gi	ade completed) College (1-4or 5	(Give	e kind of work done o DO NOT use retired	turing most of work )	ring	ob. Tana of Basiness in	2430 y
21	e filed within al Hygiene. other than " vent, II v II v	ĕ	8	College (1-40) S	(+)	Plumber			Plumbing	
pu		Be (	17. Father's Name (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle, Ma		
<u>la</u>	should be fand Mental s marked o	ဂ္	Werner J. Jac	ckson Sr.			Lulu	Davis		
Maryland	2 should be and Menta is marked and and and arked and and and and and and and and and an		19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street a	and Number or Rui	ral Route Number, (	City or Town, State, Zip	Code)
≥,	1 and 2 Health em 27 I		Mary Dorothy Jack	son (spo	ouse) 8216	Baltimor	e & Anna	polis Blv	d.,Pasadena	a. MD 21122
ore			20a. Method of Disposition	70	20b. Place of Disponentery, cre	osition (Name of matory or other place	Feb.		c. Location - City or To	
Ĕ	Pages ment of I ant; If ite ury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	J Hemoval from State fy)	1	en Cemeter			len Burnie,	. Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Line	se#2		2. Name and Addres	*		Funeral Ho	
<u> </u>	9 Q E # 9		1 Jul 2	N' YE	0.0	3111 Mou	ntain Roa	ad, Pasad	ena, MD 21]	122
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do not en					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	One datase on each in	1-6-	0.00		W ful	-	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	THENCO	مر در در در	12/10		1 monto
	Examiner		Conventially list and distance	h	UIN	G Car	200		1	3 months
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):				1	Junuly
	ecute ind trans	Examiner	that initiated events	C						
Ő,	oe exi		resulting in death) Last	Due to (or as	a consequence of):					
68760,	rtificate be executed g physician and as the burial-transi	Medical	•	d						
			IF FEMALE:	00.11						
Вох	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 ☐ Fetal death 3 [	Ectopic pregnancy			23d. Date of delive Month	•
o	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)			MOHIT	Day Year
σ.	that t ed by detac		Part II. Other significant conditions	contributing to death by	it not resulting in the u	nderlying cause gives	n in Dort I	220 Did tabas	cco use contribute to th	a source of death 0
ds,	w requires that the de been signed by the should be detached	0		on Touring to doubt be	it not resulting in the d	ndenying cause give	IIIII Fall I,	111		
Record	been	Completed						1X Yes	2 No 3 Prob	ably 4 🗌 Unknown
န္တ	: The law cate has page 2 s	臣				_		24a. Was an autopsy	prior to con	psy findings available npletion of cause of
<u>=</u>	sician: The certificate I rector, page	8						performed 1 □ Yes 2 □	d? I death?	2.☑No
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hoonite()			26. Place of Death	(Check only one)		
<del>_</del>	Phys this	은	1 Yes 2 No		nt 2 ER/Outpatier		4 L Nursing Ho		e 6 ☐ Other (Specify	<i>n</i>
5	Jing I. After funer	<u>o</u>	27. Manner of Death  D⊠Natural 5 □ Pending	28a. Date of Injur (Month, Day		Work?	?	28d. Describe how	injury occurred	
<u>S</u>	ttenc death death ttor: the	cat	2 Accident investigation 3 Suicide 6 Could not b				es 2 No			
Division of	or A after Direc in by	Certification:	4 ☐ Homicide determined	building, etc	ry - At home, farm, str . <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
_	pital burs eral filled		29a. Certifier Certifying Pt	usalalan. Ta the best	f and be a second					
:	24 hr 24 hr Fun etely	edical	(Check only one) 2 Medical Example (Check only one)	niner: On the basis of and manner sta	examination and/or in	n occurred at the tim- vestigation, in my op	e, date and place, inion, death occurr	and due to the caus ed at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the Hospital or Attending Physician: To the A hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it	Me	29b. Signature and title of certifier	and manner sta	4 -	29c. License	number	294	Date signed (Month, L	Dav. Year)
<b>,</b>			N/M	7/1/1	Tel		3/471	1	- 6	920101
•		-	30 Name and address of person who	completed cause of de	ath (Item 23a) (Tuno	Print)	11111	T	E Druey	LUIV
			( Rollas	Coned of	300	Or altal	0-7-1-0	Q. B	11mm 11/1	10(.)
	Stat	е	31. Date filed (Month, Day, Year)	32. Registra	1 [7]	0.19	WI MT)	77710	1141.2	4/
	Registra	r	FFR 1 2	2010 12	une a.	Barre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** THOMAS SAMUEL JOHN February 2010 9:45 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OAK CREST VILLAGE RENAISSANCE GRDNS Parkville Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 19, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1928 1 1 M 2 □ F Pennsylvania Director 217-20-3962 Usual Residence of Decedent with the Maryland 28a-f show 10c, City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Directo Maryland Baltimore County 1 ☐ Yes 21 No Parkville 10e. Street and Number 10g. Citizen of What Country? 8834 Walther Boulevard 21234 Pages 1 and 2 should be filed within 72 hours after death wnent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23; Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Meat Packing Processor Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Meat Sales 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Samuel John Koula Zemeki ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Nicholas John (Son) 5362 28th Street, NW, Washington, DC 20015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 2/9/2010 Baltimore, Maryland 21. Signature & Funeral Service Loghslee

Martin D. Lawson MINCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronary /Medical Due to (or as a c sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-tra Due to (or as a consequence of): Box 68760. eral Director: After this certificate has buen signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month □Yes 2□No 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 DM, CHF, Multi- Infarct 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ce tificate has autopsy performed? 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death Certification: 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐Yes 2 ☐ No the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital or hours Certifying Physician 1 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 24 within To the

State Registrar 29b. Signature and title of certifier

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- Char, MSN

address of person who completed cause of death (Item 23a) (Type, Print)

R171944

8800 Walther Blvd, Packville, NO 21234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Carolyn Kalb 14:14 PM Februar 2010 10 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bayrian Medical Center Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 1 □ M 2 🛣 F Days Hours May 2, 1 215-30-4782 75 1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21222 771 Fulbrook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steven Sitar M. Nardone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Kalb - Husband 771 Fulbrook Rd. Dundalk, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State 2-19-2010 Baltimore, Maryland Greenmount Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. Conkling Street Balto. Md e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or hear Immediate Cause (File) disease or condition resulting in death) Stroke Days Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

**Examiner** 

**Funeral** 

**Director** 

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ntal Hygiene. ted other than "natura: event, the Medical E

age 1 and 2 should be filed ont of Health and Mental H It: If item 27 is marked ot y or other traumatic even

permit. Page Department o Important: If any injury or once.

Director

Funeral

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Completed

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death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-tran ed by the a detached f To the Funeral Director: After completed filled in by the funer

Hospital or Attending Physician: The law requires that the death certificate be executed

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Certificate:

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

29b. Signature and title of certifier

Yolanda Chik

31. Date filed (Month, Day, Year)

Examiner

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	J. ————————————————————————————————————	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events	Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):  d.	
FEMALE:  3b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery  Month Day Year
art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 Yes 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed? 1 □ Yes 2 □ No □ Yes 2 □ No □ No □ No □ Yes 2 □ No □ No □ No □ No □ No □ No □ No □
Was case referred to medical examiner?	26. Place of Death (Check o	nly one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 Residence 6 Other (Specify)
7. Manner of Death  1 Natural 5 Pending 2 Accident Investigat	(Month, Day, Year) Injury work? ion M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		f. Location (Street and Number or Rural Route Number, City or Town, State)
29a, Certifier 1 Certifying P	nysician: To the best of my knowledge, death occured at the time, date and place, and	due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore, MD 21224

29d. Date signed (Month, Day, Year)

February 10, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Res-000

State Registrar

To the Hospital within 24 hours a To the Funeral C

4940 Eastern Avenue

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03429 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Muhterem Month Karatas 1739 January 29 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Aug. 28, Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 50 Turkey Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 2202 Massachusetts Ave. N.W. 20008 Turkey 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Colonel Turkish Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ali Karatas Ayse Oztas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Munevver Karatas (Wife) 2202 Massachusetts Ave. N,W, Washington, DC 20008 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/6/2010 4 ☐ Denation 5 ☐ Other (Specify) Balikesir Cemetery Balikesir, Turkey 21. Signature of Juneral Service Licensee 22 Name and Address of Ea

**Physician** /Medical Exami

Physician

/Medical

Examiner

None

10a. State

DC

Director

Funeral

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Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marting once.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

To the nospital of Attending Physician: The law requires that the death certificate be executed	(a	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	er	
to the hospital of Attending Physician; III	within 24 hours after death.	To the Funeral Director: After this certificate	completely filled in by the funeral director, pa		

	* Lennis 12	allnew	Islami	c Funeral Se Kalb Ave	ervices, Ir Brooklyn,	nc. NY 11205	
	251 De Kalb Ave., Brooklyn, NY 11205 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
	Immediate Cause (Final disease or condition resulting in death)	a. Metastatic eg	Sophage	eal cance	r		Onset and Death
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consequence of the consequence	ы):		•		
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3  Ectopic pre			23d. Date of del Month	ivery Day Year
ed by P	Part II. Other significant conditions o	ontributing to death but not resulting in	n the underlying ca	ause given in Part I.	23e. Did tobacc 1 ☐ Yes		the cause of death?
Colliple					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2   No
ט מ	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
2	1 ☐ Yes 2 💢 No		tpatient 3 DOA	1	ome 5 Residence	6 Other (Spec	ify)
allon.	27. Manner of Death  1. Natural 5 Pending (Month, Day Year)  28. Date of Injury (Month, Day Year)  28. Date of Injury (Month, Day Year)  28. Time of Injury Work?  1 Yes 2 No						
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined						ıral Route Number,
Medical Certification.	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at d/or investigation, in	t the time, date and place n my opinion, death occu	r, and due to the cause arred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
ž	29b. Signature and title of certifier	2	. 29c. l	License number	29d. D	Date signed (Month	Dav. Year)

RES-000

January 29,2010

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Toanna M. Peloquin

Doanna M. Peloquen

32. Registrar's Signature

Amend #8 per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Genevie Margaret Kirn 7:45 A M 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner Town, or Location of Death 4c. County of Death Franklin Square Hospital Center Kosedale Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, 08/26/<del>2</del> 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1944 1 □ M 2√2 F Hours Min 218 42 0298 Director 65 Yrs Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notitied at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1035 Foxridge Lane 21221 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home В Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Dembowczyk Loretta Krainer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David F. Kirn (husband) 1035 Foxridge Lane Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕶 Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 2/10/2010 Baltimore, Maryland 21. Sig al Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Rart 1 Enter the disease, shock or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tronly one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition Myocardial Physician/ 30 minutes Medical resulting in death) Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Unknown Month Day Year been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2 No ☐ Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 24 hours after death. Funeral Director: At 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | 3 | within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) William andsew Some, MD 023704 02-09-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 William Andrew Renie MD 9000 Franklin Square Dr. Baltimore, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

enevie

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1.   Consider to Name Press Manus (2014)   Tammerman Kah	0 03431	ental Hygiene 2010		rtment of He tificate of De		f Marylan	State of		for State Registrar	,		
Formation Formation   Security Number   Part	3. Time of Death	1. Decedent's Name (First, Middle, Last)  Elizabeth Zimmerman Kahl  2. Date of Death Month February 8, 2010						D				
Survival   Company   Com	2:58 P M											
Description   Disputation			cation of Death			ber)		· -		ner	Examir	
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Was descedent pregnant in the past 12 months?    FFEMALE:   Past							d			Medi	g phys as the	3/04 ficate
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24a. Was an autopsy findings prior to completion of or death?  25. Was case referred to medical examiner?  1   Yes 2   No  25. Was case referred to medical examiner?  1   Yes 2   No  26. Place of Death (Check only one)  27. Manger of Death  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Place of Death (Check only one)  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  28. Date of injury  29. Date and bate, and due to the cause(s) and manner as stated.  29. Date signed (Month, Day, Year)  29. Signature and title of certifier  29. Date signed (Month, Day, Year)  29. Date signed (Month, Day, Yea	to the cause of death?					2	Part II. Other signif	þ	n signed b	IS, F.O		
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death   Hospital:   Impatient 2   ER/Outpatient 3   DOA   Other:   4   Nursing Home 5   Residence 6   Other (Specify)  28a. Date of Injury   28b. Time of injury   28b. Time of injury   28c. Injury at work?   1   Yes 2   No   No   No   No   No   No   No	completion of cause of	autopsy prior to comp performed? death?					997	emo	+ ch	Somplet	ate has bee page 2 sho	HECOR The law req
Second   S		nly one)	of Death (Check only o	Othorn			Hospital:	. 19	examiner?	Be	sertific ector,	ician:
Note: The part of the part of	cify)	// (		3 LI DUA	28b. Time of	f injury	1 🔲 Ir 28a. Date o	No I			er this eral dir	V TC
The properties of the properti		Table Hall Hydry declared		work?	injury	n, Day, Year)		Investigation	2 Accident	ficat	sath. or: Afte he fund	OTI (
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) A CKA Foraday MD 63MC SVIVE \$103 Date Model.	ural Route Number,			et, factory, office			28e. Place c				s after de I Directo d in by t	JIVISI
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	cause(s) and manner stated.	taliana alaba anad alaba anad alaba an atau an ara-	noth and wood at the time	nation in my opinion o	n and/or invoct	of examination	ner: On the basis	Medical Exami	(Check 2	Nedical	n 24 nours le Funeral oleted fille	L ne Hospitz
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Alexa Faraday MD 63MC Sure 5103 Dall MD21.		29d. Date signed (Month, Date 137 2/9/10	ou 4 393	29c. License nu	10	Cun 1	enad				To the come	Tot
	4021204	3 Salt Mr.	ite \$103	3 4c Si	n 23a) (Type, P	of death (Item	ompleted cause		30. Name and addre			
State S1. Date filed (Month, Day, Year)  32. Régistra 's Signature  Registrar  558 1 2 2010				bares	ture	gistra 's Signat	32. Re	Day, Year)	31. Date filed (Monti			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#7perFH, G900, 2/12/2010, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Veal 00 M 2060 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) or Location of Death Examiner Security Number Age (In yrs. last birthday, 9 Birthplac **Funeral** Days 1 M 2 F Hours Director 1a bama death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No by Funeral Director Imore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced Blac Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) Private 17. Father's Name (First, Middle, Last) ٥ (niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State 2010 tus Mem. Park rbutus, Md. 21. Signature Juneral Service Licensee 22. Name and Address of Facility

JOSEPH L. RUSS

22.22 W. North uneral Ho ve. Balto. atel serves Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Small Bowe Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a cons Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 □ No 3 ☐ Probably 4☐ Unknown Completed degree Values 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ ★6 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31464 MI) 213110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , SZI N. EUTAN ST Suite 308 BALTIMORE MD 2001 SHMI MD State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month EMORY WICH LAF 010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 612 McCoullough Circle Baltimore NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year 0 5 - 1 1 - 4 4 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) VA 7. Age (In yrs. last birthday) 65 1 ☑ M 2 □ F Months 219-40-4083 Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits Director MD NA Baltimore X1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 McCoullough Circle 21201 USA Funeral 14. Race - American Indian, Black, White, et African 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) rmed Forces? ☐Yes 2☐X\o 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No <u></u> If Yes, Give Year or Dates: Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th Grade College (1-4or 5+) Laborer various trades 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Leftwich Louise ပ Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Leftwich-Wife 612 McCollough Circle Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery 02-12-10 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Street Baltimore. Gilmor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final therescher 0 H disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🗷 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 ☐ Yes 📆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ∏ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner requires that the death certificate be executed and burial-tra P.O. Box 68760, attending physician for use as the buria signed by the a I be detached f Division of Vital Records, page 2 should been has this certificate Physician: director, funeral After 1

**Physician** 

/Medical

Examiner Physician/Medical þ Completed Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumatic event, it is Modical Evan near must be suited once.

Baltimore, Maryland 21215-0036

ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t filled in by the To the I within 2 To the I

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of certifier

29c. License numbe

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Sa 9.45 AM DWY Jar 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Vindobona Nursing Home Frederick Frederick 5. Social Security Number f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 6. Sex Year) 1 □ M 2 💢 F Months Days Hours 116-30-8693 95 16, Director Illinois April 1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Modical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ▼Yes 2 No Directo Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1175 Professional Court 21740 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 ò 1 ☐Yes 2 XNo Specify. Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Actress Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Adolph Koch Louisa Mahler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Lowry (Daughter-in-Law) 200 S. Maple Ave., Purcellville, VA 20132 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sleepy Hollow Cemetery 1/30/10 Sleepy Hollow, NY 5 ☐ Other (Specify) 21. Signature of Funeral Service Licursee 22. Name and Address of Facility
Dwyer & Vanderbilt 90 North Broadway, Tarrytown, NY 10591 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Dementic year s /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed oertificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 🛛 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes e Hospital or Attending Physiclan: 24 hours after death. Funeral Director; After this certifica director, | 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Naccident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the within To the of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

2

State Registrar Hiren Shah ( B1. Date filed (Month, Day, Year) FEB 12 2010



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David B. Lawrence, I 2010 February AM 2:53 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death 4604 Bucks Schoolhouse Road Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min Dec. 31 Director 276-38-4651 Yrs 67 Ohio Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4604 Bucks Schoolhouse Road 21237 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, rmed Forces?
X Yes 2 \( \sigma\) No Completed by Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. 1961-64 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. narked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clyde Lawrence Juel Brammer permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Ann Lawrence wife 4604 Bucks Schoolhouse Road; Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Hammondsville Cemetery 02/15/2010 Hammondsville, OH 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final cancinima non-small Physician. disease or condition resulting in death) Medical Due to (or se a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consuluence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed? 1 Yes 2 □ No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: မှ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗀 No Accident Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number m

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Nouth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ang hall

31. Date filed (Month, Day, Year)

FEB 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03437 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Februar Robert С. 1:50 PM Liller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death BAltimore Was Glen Burnie ANNE ARUNDEL Medical CENTER Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Y Aug. 24 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days **Director** Yrs Country) 216-36-1192 1938 Mary Land Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Homeland Road U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Divorced If Yes, Give Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Meat Manager A & P Supermarket Be aryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Liller A1ma Foreback 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Σ Annette L. Liller (Wife) 103 Homeland Road Pasadena. Maryland 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 02/05/10 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee .22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryla 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) cardia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit RINAR that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv deatn? 1 ☐ Yes 2 (XX)No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other; ဂ္ 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 03.

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Munshauer 10:55 QM Florence 02 09 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore University 3 Maryland Medical center N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 85 Yrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M ₹₹ F Months Days Hours Min 6/17/1924 MD 219-20-0857 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov 28a-f shov MD 1 ☐ Yes XX No Director Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be recons. 604 Brenda Way 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 No If Yes, Give Year or Dates Specify. þ Specify 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker her home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Nickoles Myrtle Merryman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Frebertshauser (daughter) 2333 Sykesville Rd. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State S. Carroll Crematory | 2/12/2010 | Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service RILL Name and Address of Facility neral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Anerysmal Subarachnoid Hemmorhas disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760, 🥰 resulting in death) Last Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I rector, page 2 s autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this

y filled in by the funeral di this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M-D AU41764351319889 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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32. Registrar's Signature

21030

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 10e & 19b, per FH G900 2/12/10 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1738 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center NA 5. Social Security Number 7. Age (In yrs. last birthday) Sex 1 M 2 □ F If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Birtrip Country MD (Month, Day, Year 01-08-35 215-30-9648 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Rosedale Yes 2 No Baltimore 10e. Street and Numberimble 10f. Zip Code 10g. Citizen of What Country? 8825 21237 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. African 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Completed Specify: American 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) entary/Seconday (0-12) h Grade NA College (1-4 or 5+) Domino Sugar Co. Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Gilbert Gibson Murel Pauline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trible Way Rosedale, Maryland 21237 Ayanna James-Sister 8825 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Western Star Cem 02-13-10 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Funeral Home P.A. Baltimore, MD 21217 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Street 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due t (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 💢 No 24a. Was an autopsy Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 🗓 1 pnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

NP1 1104051945

225. Greene St. Baltimore, ND 21201

Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smelter

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RL MAGEE /Medical 0 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 4212 Deer Randa11stown Park Rd. Ba1timore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) XXM 2□ F Months Days Hours 220-22-1412 Director 81 June 5, 1928 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It is Mic. Let 1. Director 1 ☐ Yes X No MD Baltimore Randa11stown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4212 Deer Park Rd. Funeral 21133 hours after death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes ¾ No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □Yes **X**XNo ģ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Mechanical Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f es 1 and 2 should be of Health and Menta !! Joseph Oliver Magee Ella Susanna Baier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsa Lillian Magee/Wife 4212 Deer Park Rd. Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other paran 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State or other place 4 □ Donation 5 □ Other (Specify) 2/13/10 Randallstown, MD Church Cemetery 21. Signature of Fune I Service Licenses 22. Name and Address of FacilitEckhardt funeral Chape 1 P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** ATROLOSC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician for use as the buria The law requires that the death certificate be Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death Month Day Ye ar 5 ☐ Other (specify) o ed by the 9 Unknown σ. signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No Completed 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 autopsy certificate 2**X**No 1 ☐Yes 2 ☐ No 1 □Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending investigation Year after death 2 Accident 1 ☐ Yes 2 No filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Funeral I 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) the To the within 7 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Year)

**FEB 12** 

Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 34 PM inda Moms Feb 010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth HOSDITO Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🔀 F Months Days 219-86-5983 Director Usual Residence of Decedent 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evol. item must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hyglen, Important: If item 27 is marked other than any injury or other traumatic successions. 1244 NIA 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Malden Surname) Be MOrra Ernes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) michelle morris 900 - aughter eppin Ct 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 7-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee MU 23a. Parri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate use (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hepatht

Due to (or as a consequence of): burial-tran law requires that the death certificate be execu attending physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the detached signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Anemia, Thrombo cutopenia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 perform 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏ Yes 2 🛂 🗖 Certification: To 1 Thipatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760 P.O. Records, Hospital or Attending Physician: The Division of Vital within 24 hours after death To the Funeral Director: filled in by

29a. Certifier (Check only one)

29b. Signature and title of certifier

RES OOI MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hanove Baitimore mill 31. Date filed (Month, Day, Year) FEB 1 2 2010

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2010 Mary Catherine Meck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1257 Limit Avenue N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** May 28. 1930 1 □ M 2 💢 F Days Hours 79 Yrs. Maryland Director 218-26-3628 Usual Residence of Decede 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits be notified 1 🌠 Yes 2 🗆 No N/A Maryland Baltimore ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1257 Limit Avenue U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Banking 12 years Administr<u>ation</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Mary Murphy and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Meck (daughter) Forest Drive Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 2**-**9-10 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Dulmonary Medical resulting in death) Due to (or as a consequence of): **Examiner** chstructive Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cardiovascular arterioslerotic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of stroke 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 HNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) D 00 30127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Osler Drive Towson 32. Registrar's S Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 9.30 AM 2010 Ann Theresa Meren FEB /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Raltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 29,1931 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 185-24-7989 78 Director Pennsylvania Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐Yes 27 No Director Maryland | Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23a or any injury or other traumatic event, the Medical Examiner must be read injury or other traumatic event, the Medical Examiner must be read. 8810 Walther Blvd Apt 1631 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Conway Trene Walsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis F. Meren Husband 8810 Walther Blvd Apt 1631; Parkville, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Cemetery 2/9/2010 Heart Cemetery 2/9/2010 | Bowie, MD
22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc. 4 Donation 5 ☐ Other (Specify)/ 21. Si mature of Funeral Service Licen 1630 Edmondson Avenue; Cator complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician INFECTIVE ENDOCAR DITIE /Medical Due to (or as a consequence of): Examiner POST LAPAROTOMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) LOWER GI BLEED Exami burial-tran Due to (or as a consequence of): physician Physician/Medical the as 1 IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ CORONARY ARTERY DISCASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No END STAGE RENAL DISEASE ON PD 24a. Was an page 2 autopsy performed certificate GRAVES DISCASE Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Res 000 MD. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLVD BALTIMORE 21239 SAYED KAZI 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Amend 20b, per fin g900 2/19/10 Endelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Ranallo Molite 2:40 A Marie February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist **Baltimore** Towson 8. Date of Birth (Month, Day, Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔽 F Months Days Hours Min New York Director Yrs. 119-16-8616 January Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Maryland 1 ☐ Yes 2XXNo Baltimore Cockeysville 10e. Street and Number 10f. Zíp Code 10g. Citizen of What Country? 286 Lord Byron Lane 21030 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. 3X Widowed 4 □ Divorced Specify: White Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ranallo Stella John Motta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 2701 Stevens Court</u> <u>John J. Molite</u> Baldwin, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) March 4,2010 Arlington Arlington Nat. Cem. Virginia grature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Qnset and Death Ph sician/ Aspiration Pheumoni disease or condition 6245 Medical resulting in death) Due to for as a consequence of). Examiner Cance Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for on a connectionne on attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cardiomyopethy 1 ☐ Yes 2 🖎 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate he funeral director, page performed? Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? neral Director: A I filled in by the f Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Charles TIMION MD HARVE 6101 trar's Signature State Registrar

Please Type or Print in Black Indelible hkit Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician < Donsey Day Year :00 AM ber 010 /Medical 4a. Facility Name (If not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brinton Baltmans N/ OF Woods If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 F Months Days Hours Min 93 Director 239-24-9544 NC 12/3/1916 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipiny or other traumatic event, The Medical Experiment 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director MD N/A 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2328 E. Hoffman St. 21213 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No frican 1 ☐Yes 2√□No Specify: 3 Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Home Wife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mollie Mary Jane Strickland Be Christopher Columbus Tanksmith ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2328 E. Hoffman St., Balt., MD 21213 Mary M. Dockery/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/16/10 Baltimore, MD Mt. Zion Cem. 21. Signature of Funeral Service License Hari P. Close F.Svs, PA MD 21206-5105 Belair Rd, Balt., MD 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and burial-tran Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 □ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NIZOBA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryla	_	artment of F tificate of E		lental Hygle/ Reg	201	0	03446
	Physicia		1. Decedent's Name (First, Middle, Last)  Janet	Ε.	Molby			2. Date of Death Month February	Day 4, 201	/ear	3. Time of Death 3:40 P M
	Medic Examin		4a. Facility Name (if not institution, give st		MOLDY	4b. City, Town, or	Location of Death	rebruary	4c. County of		3:40 P
			8349 Forest Drive			Pasade			Anne	<u>Arund</u>	le1
	Funeral Director		5. Social Security Number  215–46–6285  Usual Residence of Decedent	7. Age ( <i>In yn</i>	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 30,	946	9. Birthplac Country Mary I	ce (State or Foreign ) .and
	s filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County  Maryland Anne Art		City, Town or Locasadena	cation				10d	I. Inside City Limits 1 ☐ Yes 2 🔏 No
	the N or 28	直	10e. Street and Number	inder   1 d	Baacha	10f. Zip Code		10g	. Citizen of Wh	at Country	n
	h with 1s 23e nust b	nera	8349 Forest Drive			21122			U.	S.A.	
36	filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 🕅 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2 🛣 No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	0:6::	American White, etc	
8	hours natura ical E	Completed	15. Decedent's Edu		16a. Deced	lent's Usual Occup	ation	16	b. Kind of Busi		
Maryland 21215-0036	in 72 le. nan "r Med	E G	(Specify only highest grad Elementary/Seconday (0-12)	le completed) College (1-4 or 5+)	(Give i	kind of work done o O NOT use retired)	during most of worki	ing			
21	ed within Hygiene. other tha ent, the I		12	2	Reg	gistered				Gene	ral Hospita
gue	e filec ntal H ed ot ever	To Be	17. Father's Name (First, Middle, Last)	17	0			e (First, Middle, Maid	den Surname)		
٦	should be file h and Mental H 7 is marked o traumatic eve		Franklyn  19a. Informant's Name/Relationship (Typ	E.	Green	an Addrona (Street	Anna	M .  Al Route Number, Cit	v or Town Stat		ith
$\mathbf{\Sigma}$	12 shalth ar 27 is r trau		George F. Molby (H					idena, Mar			
Baltimore,	permit. Page 1 and 2 should be i Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20k Removal from State	b. Place of Dispo	sition (Name of natory or other plac	e)	Date 20	c. Location - C	ity or Towr	
Balti	permit. Departn Imports any inju		21. Signature of Fureral Service Licenses	Him		Name and Address AcCully-P 3204 Moun		uneral Ho Pasadena			
	Pnysician/ Medical Examiner	er	23a. Par 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate		equence of):	er the mode of dyin	g, such as cardiac c	or respiratory arrest,		l ir	pproximate terval Between inset and Death
0	cate be executed physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg  1  Live Birth 2  F  4  Pregnant at time 9  Unknown	Fetal death 3 _	Ectopic pregnand Other (specify)	÷у		23d. Date Month	,	
ds, P.O.	luires that the signed by all the detact	þ	Part II. Other significant conditions cor	tributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.				cause of death?
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed						24a. Was an autopsy performe	prio		/ findings available oletion of cause of
tal	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			ace of Death (Check	k only one)			
ξ	Physical this call directions	일	1 ☐ Yes 2 HNo	1 Inpatient 2	ER/Outpatier 28b. Time of		4 U Nursing Ho	me 5 Residenc		(Specify)	
n o	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		work		28d. Describe how i	njury occurred		
)ivisio	al or Atten s after deal I Director; d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe				28f. Location (Stree City or Town, S		or Rural Ro	oute Number,
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director. After this certifical completed filled in by the funeral director,	Medical	(Chook 2/ Madical Examin	cian: To the best of my kn er: On the basis of examina Practioner: To the best of	ation and/or invoc	tigation in my opinic	an doath occurred at	the time date and r	lace and due to	a the called	e(s) and manner stated.
	Not To t		29b. Signature and title of certifying Nurse 29b. Signature and title of certifier  30. Name and address of person who co  31. Date filed (Month, Day, Year)  FEB 1 2 201	M.D		29c. License	9505	29d F-e	Date signed (I	Month, Day	y, Year)
			30. Name and address of person who co	mpleted cause of death (If	tem 23a) (Type, F 5 Hosp	bital b	v, Glan	Bum	ie, M	0 2	1061
	Sta Registr	te ar	FEB 1 2 201	32. Jegistrar's Sig	gnature .	arkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiene

			For State Registrar	State of Ma	arylan		artment of F rtificate of L		and M		giene Reg. No. 2	2010	034	47
Die	inin	,	Decedent's Name (First, Middle, L	Last)						2. Date of Dea	ath		3. Time of Dea	ath
	ysicia Medic		Jordan Lee	Neville						Month Februar	Day	2010	3:15 7	
and the same of	xamin		4a. Facility Name (if not institution, g.				4b. City, Town, or	r Location of			-	ounty of Deat		-W-1
			433 Virginia Ave				Essex					ltimor	:e	
	neral			1 🗙 M 2 □ F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Yea <i>r</i> )	9. Bird Co	thplace (State or Fo	oreign
	ector		215-46-7229 Usual Residence of Decedent		62	Tio.				2/23/1	947		ryland	
and	lat at	į	10a. State 10b. County		10c. Cit	ty, Town or Loc	cation	-					10d. Inside City Li	.lmits
Maryli %a-f	tiffied	Funeral Director	Maryland Baltin	nore	Esse	~v							1 ☐ Yes 2 €	₩ No
the l	o e no	<u> </u>	10e, Street and Number	TOTE	LESSE	2X	10f. Zip Code	,,,			10g. Citizer	n of What Co		<u> </u>
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death	ner n		11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S		Was Decedent of Hi f Yes, specify Cuba	ispanic Origi	in? (Spec	ify Yes or No-		. Race - Ame		
36 after after ".	camil.	by	1 Never Married 2 Married	1 Ves 2 If Yes, Give	No 10		I ☐ Yes 2 🛣 No		1 00110 11	110411, 0101,	50	Black, White ecify:	a, etc.	
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/and 1 be f Aenta	tic ev	욘	Frank Nevill	le				Mabel		Abbot		There is any		
, Maryland 21215 d 2 should be filed within 72 laith and Mental Hygiene.	ırıma		19a. Informant's Name/Relationship			19b. Mailin	ng Address (Street a					wn, State, Zir	Code)	
, M nd 2 s salth :	er tra		Robin Fitch (Dau	uahter)			Sparrow I						*	
of He	ŧ	;	20a. Method of Disposition	-		Place of Dispos	sition (Name of natory or other plac			ate		tion - City or		
Page ment	, o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				Cemetery		2/13/	/2010	Ralt	imore.	Maryland	٦
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Innortant: If item 27 is marked other than "natural". or items 23a or 28a-f show	any inju	_	21. Signature of Funeral Service Lice	ansee	1000	22.	. Name and Addres	ss of Facility				55		=:10 To
<b>10</b> % & 5	. g g		7			173	uzdzinsk 07 old E	i fune asterr	eraı 1 Ave	Home P	A ssex,	Maryl	and 21221	1
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused y one cause on each line	I the death	h. Do not ente	r the mode of dying	g, such as ca	ardiac or	respiratory arm	est,		Approximate Interval Between	
Physic		1	Immediate Cause (Final isease or condition	LUN	6- 6	CANCE	FR.						Onset and Deati	
Med Exam	dical niner		resulting in death)	Due to (or as a										
		7	Sequentially list conditions,	b. ———										
D.	#S	Examiner	cause. Enter Underlying	Due to (or se s	3 DO INDAGE	lente of,:								
ecute	-trans	Exar	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	e consequ	ience off:								
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	the burial-transit		rooding in douch and		10011001	161.00 0.7.								
<b>760</b> cate b physi	the s	edical		<b>d</b>										
Sertifi oding	for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							224	Data of dal	iven	
SOX eath o	d for u	icia	in the past 12 months?	1 ☐ Live Birth : 4 ☐ Pregnant at			Ectopic pregnance Other (specify)	У			230	d. Date of deli Month	Day Year	
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Frat that	e deta	by P	Part II. Other significant conditions	contributing to death bu	ut not resi	ulting in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco use d	contribute to	the cause of death'	?
dS, juires en sig	d blu	ed	4							1 □ Y	res 2□N	No 3 Pr	robably 4 🗌 Unkr	nown
w rec	sho	pet								24a. Was a		4b. Were aut	topsy findings availa	able
<b>ec</b> The la	page 2 s	Completed									med?	death?	completion of cause	of of
Division of Vital Records, P.O. Box tall or Attending Physician: The law requires that the death crs after cleath.  Is after cleath.  In Director: After this certificate has been signed by the attention.	tor, p		25. Was case referred to medical				26. Pla	ace of Death	(Check c	1 Yes	2 A I NO	1 ⊔ tes	2 🗆 No	
VIÇ nysici	direc	၉	examiner? 1 Yes 2 XNo	Hospital:	ent 2 🗆	ER/Outpatient	Othe	· ·		e 5 🔀 Reside	ence 6 $\square$	Other (Speci	ifu)	
Of ng Pt fter tt	inera		27. Manner of Death 1   Manner of Death 5 □ Pending	28a. Date of injur (Month, Day,	ry	28b. Time of injury	28c. Injury work?	/ at		d. Describe ho			97	
lon tendii leath.	the fu	<u> </u>	2 Accident Investigati	tion				Yes 2 N	10					
VISI or Att fter d firect	n by	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At hor . (Specify)	me, farm, stre	et, factory, office		28	Bf, Location (St City or Town	reet and Nu	ımber or Run	al Route Number,	
Dital cours a gral D	illed ii.			W					13					
Hosp 24 ha Fune	ited fi	Medical	(Check 2 L. Medical Exam	hysician: To the best of r miner: On the basis of ex	kamination	and/or investi-	gation, in my opinior	n, death occi	urred at th	ne time, date an	nd place, and	d due to the c	ause(s) and manner	stated.
ithin (	aldmo		only one) 3 Certifying Nu 29b. Signature and title of certifier	urse Practioner: To the b	pest of my	knowledge, de	eath occurred at the 29c. License	e time, date a	ind place,	and due to the	cause(s) and	d manner as s	stated.	
	8	ľ	250. Oighatare and the of certifier		- MI	>						igned (Month,		
- 1		-	20. Name and address of several value		4  - (14	00-) Æ P		5 657	18.	λ		2/0	8/2010	·
101	`		30. Name and address of person who David Perry, M.I	D., 9105 Fr	ankl:	in Squa	are Drive	, Suif	te 1	00, Bal	timor	e, Md.	. 21237-4	930
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 3:14 PM Jean 099 ٤. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min 1 🗆 M 2 🖵 F Days Hours Country) Director 212-24-7492 1930 Penn Jan. Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 Yes 2 X No Maryland Carroll Manchester ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 Bachman Rd. 21102 items 23a Funeral death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. Specify: Completed 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home House Keeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H 27 is marked of traumatic ever ဂ Page 1 and 2 should be ment of Health and Ments Harry Edward Kemper Maybell Alberta Shetter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Linda Black - daughter 3343 Kensington Sq., Manchester, MD. 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 13,2010 Westminster, Johns Church Cem. Feb. Sτ 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A . Hall Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ symptomatic without disease or condition resulting in death) Bradycardia ability Medical Due to (or as a consequence of) Examiner 40 maintain intriusic pacemaker. Sequentially list conditions, Examine Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury bunial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Year Day 9 Unknown a 🗍 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Atrial Fibrillation 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 1811122740 2/9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 MP Baltrinore, Greene Alan Kimh parker 31. Date filed (Month, Day, Year) 32. F egistrar's Signature State Registrar **ORIGINAL** 

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death () Neill Month **Physician** Kathleen 02:19 AM February 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-48-6980 60 Director February 2,2010 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director tXX Yes 2 □ No Maryland None Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 14417 Norwood Road 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1XX Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify 9 Specify White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Me Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Baltimore City Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Lawrence Richard O'Neill Helen Elizabeth Hausamann မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Sharon PO'Neill Sister 2026 Rollingwood Road Catonsville Maryland 21228 item 2 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 3 Removal from State GreenMount Crematory Feb 8,2010 Donation 5 - Other (Specify) Baltimore Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ture of Funeral Sen 6500 York Road Baltimore, Maryland 21212 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. 23a Part 1 Enter the disease complication Approximate Interval Between shock, or heart failure. Immediate Cause (Final Onset and Death **Physician** Death Drain disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Subarachoid hemorrhage Sequentially list conditions Examiner tany, leading to initiadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Rupture of aneurysn attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 2 X No page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' Yes 2 No 1 Yes mpletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 X No 1XInpatient 2 - ER/Outpatient ٩ 3 🗌 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director; After or Attending 1 Natural 5 Pending investigation Injury 1 Yes 2 🗌 No death. 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after City or Town, State) 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2ES-000 February 3,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ryan Fellino 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) FEB 1 2 2010

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Herbert Morgan Peoples February 1 2010 4:35 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 15 Cinnamon Circle Apt. 2D Randalistown Baltimore 5. Social Security Number 6. Sex 1∆ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 5-16-1945 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Year) 240-70-6633 Director 64 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at an one. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15 Cinnamon Circle, Apt 2D 21133 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify. Specify: African-American 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Truck Driver Kessler Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert J. Peoples ပ Mary E. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iva Potts/Sister 4035 Peanut Plant Road, Elizabethtown, NC 28337 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State King Mamorial Park 2-6-2010 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, ₩ resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day 2 □ No 9 Unknown 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ■ No autopsy performed? emia ours after death.

leral Director: After this certifical filled in by the funeral director, I 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 ☐ Yes 2 ♣ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month AG ( 50 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Northwest Hospital Center Baltimore City N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2/7/F Months Days Hours Min Director 217-16-5296 April 4,1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be mutified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore Co. 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7161 Baltimore Street by Funeral 21224 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Clerk Administration 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Sophye Cobry Samue1 Goldstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7161 Baltimore Street Baltimore, Maryland 21224 Stewart Pagliughi (Son) 19 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  $2/\frac{10}{2010}$ Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Fundamental Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. oproximate Iterval Between Immediate Cause (Final disease or condition resulting in death) **Physician** heros /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year □Yes 2□No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? ģ cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed **Unknown** 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1∐Yes 2**7** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 Oth 5 🗌 Residence 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Hilda B. Pencek February 8,2010 2:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Brightwood Center Lutherville Balto. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age ( If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Days Hours Director 220-24-5432 July 25,1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2X No Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9537 Bauer Avenue 21236 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Assembly Line Worker Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Pencek Emelia Krupa ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester Stewart 2822 Cross Country Ct. Fallston, Md. 21047 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 2-12-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 Vell a. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) POXI **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ COLITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed DIVERTICULI 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No performed<sup>1</sup> this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K R-GAN-CARDEN, MD, 6701 NCHARLES ST, 4051 BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 2 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hy	giene		
			Registrar  Cel  Decedent's Name (First, Middle, Last)	rtificate of Death		Reg. No. 2010 03453		
	Physici Med		Cha Dhimphanh		2. Date of De Month	Day Year		
	Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	teb h	08 2010 8 20 P M  4c. County of Death		
			Union Memorial Hospital  5. Social Security Number 16. Sex 17. Age In was last high day.	Baltimore				
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last birthday</i> ) 73 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) Laos		
	ld now	· -	Usual Residence of Decedent					
	larylan <b>3a-f sh</b> ified a	ecto	10b. County 10c. City, Town or Lo  MD Baltimore Perry Hall			10d. Inside City Limits 1 □ Yes 2 ☑ No		
	the Manager	Į.	MD   Baltimore   Perry Hall	10f. Zip Code		10g. Citizen of What Country?		
	th with ms 23, must	Inera	4620 Forge Acre Drive	21128		USA		
ധ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married	Vas Decedent of Hispanic Origin? (S <sub>l</sub> f Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.		
003	ursaft :ural", al Exal	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	☐ Yes 2 🕅 No Specify:		Specify: Asian		
15-	72 ho n "nat Medica	nple	15. Decedent's Education 16a. Decedent's Education (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of wor	rking	16b. Kind of Business Industry		
212	within giene. er tha			ONOT use retired)		Asbestos Removal		
and	12 should be filed valth and Mental Hyg 27 is marked other traumatic event,	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle,			
چ	ould b nd Mer mark matic	-	1 d Tonifei d	Shew Ph				
ž,	id 2 sh ealth a n 27 is er trau		130, Walli	g Address (Street and Number or Ru Forge Acre Drive				
ore	t of Healt fitem 2 or other		20a. Method of Disposition 20b. Place of Dispo		Date	20c. Location - City or Town, State		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hinry or other traumatic event; the Medical Examiner must be notified at any nive.		4 Donation 3 Other (Specify) Hilltop S	ervice Corp. 2/1	8/10	Towson, MD		
Ba	permit. Departr Importa any inju			Name and Address of Facility  CK Towson Funera	1 Home	1050 York Road Inc. Towson, MD 21204		
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.		07 30 44	Interval Between		
00	ate be executed obysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to himself the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence or).  C. Due to (or as a consequence of):  d.					
7. BOX 68/	death certific ne attending p ed for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year		
7. O	s that igned I be det	ğ	Part II. Other significant conditions contributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tol	pacco use contribute to the cause of death?		
SDI	require	eted			1 🗆 Y	es 2 No 3 Probably 4 Unknown		
Vital Records,	The law requires that the arte has been signed by the page 2 should be detach	Completed			24a. Was a autops perforr	prior to completion of cause of death?		
<u> </u>	cian:	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	1 ☐ Yes k only one)	2 No 1 Yes 2 No		
5	Physi r this c eral din	<u>ان</u>	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of	3 DOA Other: 4 Nursing Ho		ence 6 Other (Specify)		
	ath. r: Afte	icate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work?  M 1  Yes 2  No	28d. Describe ho	w injury occurred		
DIVISION	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		City or Town			
	re Hosp 24 ho e Fune bleted f	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death or 2 Medical Examiner: On the basis of examination and/or investigation only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death or 2 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the basis of examination and/or investigation or 3 Medical Examiner: On the basis of examination and/or investigation or 3 Medical Examiner: On the basis of examination and/or investigation or 3 Medical Examiner: On the basis of examination and/or investigation or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge, death or 3 Medical Examiner: On the best of my knowledge and the best of	ation in my opinion death occurred a	the time date and	d place and due to the equeco(e) and manner stated		
	Vithir Vong		29b. Signature and title of certifier	29c. License number	2:	eause(s) and manner as stated.  9d. Date signed (Month, Day, Year)		
			MACO	AT 243894	6	Feb, 08, 2010		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	sortal OALF IIa	Ida DIVI.	III Bultimore MAN 2101 0		
	Stat Registra		Moid Al Chatrif, Union Memorial Ho 31. Date filed (Month, Day, Year) 32. Registrar's Signature J. A	face	( ) V	7, 1 sattle role, NID CICLA		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pillas February 20T0 Diana J. 06 12:34 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore 4b. City, Town, or Location of Death Gilchrist Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birtholace (State or Foreign 1 [] M 2 [X] F Months Days Hours June 16. 220-42-9617 Director 69 Maryla<u>nd</u> 1940 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits or 28a-f Md. Baltimore Lutherville 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 108 W. Seminary Ave. 21093 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 X Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. I's marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Child Counselor Johns Hopkins 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pillas Mary Constantinides permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jeffrey Pillas/ Brother 3 Wendslow Place Lutherville, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greek Orthodox Cem. 2-15-10 Woodlawn, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Townson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition preast cancer COLIS Medical resulting in death) Due to (or as a consequence of): Examiner gastrointestinal Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to forces aim a secouring on acute henahe and-trar Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 9 Unknown Other (specify) Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, coronary artery discase Completed 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 X N death? 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director; a 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) H D5 P1C  $\square$ မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0069536 Black February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHA RINE 6701 N. CHARLES ST, BALTIMORE MD 21204 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical FEBRUARY 8,2010 F8:00 City, Town, or Location of Death Facility Name (if not institution, give street and p Examiner 4b. County of Deat BURNIE **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Months Min June 15 Director 217-40-9662 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🛂 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8415 Gullane Court 21122 U.S.A. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Deputy Chief A.A. County Fire Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es arment of Health and Menta insportant: If item 27 is marked up injury or other traumation Phe1ps Regina Lorenz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8415 Gullane Court Pasadena, Tonna L. Phelps (Wife) Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 【XCremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 02/13/2010 Atlantic Cremation Glen Burnie, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death disease or condition SUIDED JANTEST WOOTZAS 34 HOURS Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed CORDHARY ARTERY DISEASE, DIABETES MELLITUS, CONCESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of JAW147 TAA3H 24a. Was an autopsy performed death? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 X Yes 2 🗆 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury

and Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 peen s has

as the bunal-transit signed by the attending physician I be detached for use as the best within 24 hours after death.

To the Funeral Director: After this certificate! filled in by the funeral director,

28a-f shov

5

or items 23a

and Mental Hygiene. is marked other than "natural",

Physician.

Maryland 21215-0036

Baltimore,

the Medical Examiner must be notified at

Certificate: To Be work? 1 ☐ Yes 2 ☐ No. Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number OH a wolding ord mulling D0065714 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 2 2010

GUILLEMMO JOSE GIANBAECO 301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

FEBRUARY 8, 2010

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		٠	For State Registrar	State of Maryla		artment of Hea tificate of Dea			giene Reg. No. 201	0 03456
	Dhusisis	/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physicia Medic		Lawrence William Robert					Month Februar	y 3 <sup>ay</sup> 201.0	8:25 a.M
	Examin	er	4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or Lo	cation of Death		4c. County of D	
			Gilchrist Hospice  5. Social Security Number 6. Sex	17.4	Anna to trade at 1	TOWSON  If Under 1 Year If	Under 24 Hrs.		Baltin	
	Funeral Director		212-46-7364 <sup>1 X</sup>	M 2 □ F	i. last birthday) 63Yrs.		lours Min.	8. Date of Birt (Month, Date) 2-12-1	year) 9. ( 546	Birthplace (State or Foreign Country)
	d fow	_	Usual Residence of Decedent  10a. State 10b. County	100 (	City, Town or Loc	notion				dod beside O'bellies's
	ırylan 1-f sh ied a	cto		100.0	-					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28g	Dia.	MD n/a  10e, Street and Number		Balti	10f. Zip Code			10g. Citizen of What	
	vith th	Funeral Director	1431 N. Carey Street Ap	t 106		21217			USA.	Country
	ems er mu	n.		12. Was Decedent Ever in U		Vas Decedent of Hispa	anic Origin? (Spe	ecify Yes or No-		merican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🂢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		Yes, specify Cuban, N		Rican, etc.)	Black, W Specify: A	hite, etc. frican-American
5-0	2 hou "natu	plet	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occupation	n na most of worki	ina	16b. Kind of Busine	ss Industry
121	thin 7; nne. <b>than</b>	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	O NOT use retired)		9	01 D 14	
7	Hygie Hygie other ont, th	Be C	10th 17. Father's Name (First, Middle, Last)		I Int	<u>erior Designa</u>		n /Firest Adioballa	Olga Reality Maiden Surname)	У
Maryland	be file ental I ked c ked c	10	John Robertson			10	Mattie 1		Maiden Surname)	
ary	nd Mi		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street and			r. City or Town. State.	Zip Code)
ž	id 2 sh salth a n 27 is er tra		Lakiia Robertson/daugh	ter		Auchentoroly				<i>-</i>
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b.	. Place of Dispos cemetery, crem	sition (Name of natory or other place)	ı	Date	20c. Location - City	or Town, State
Baltimore,	t. Pag tment tant: njury o		4 Donation 5 Other (Specify)	Ar		orial Park	2-9-20		Arbutus, MD	
Bal	permit Depar Impor any in once,		21. Signature of Funeral Service Licenser	U. lelefte		Name and Address o OO Liberty Ro				t Balto. Co.
			23a. Party. Enter the disease, or compli shock, or heart failure. List only one	cations that caused the de cause on each line.	ath. Do not ente	r the mode of dying, s	uch as cardiac o	r respiratory arr	est,	Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition	Esapha	sent	concer				Onset and Death
	Medical Examiner		resulting in death)	Due to (or s a conse	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):			+		
5	icate be executed physician and s the bunal-transit	Examiner	Cause (Disease or linjury that initiated events							
<i>y</i> ′	e exec cian al unaî-t	al E	resulting in death) Last	Due to (or as a conse	equence of):					
760	ate be	edical								
687	aath certific attending     for use as	/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr	nancy				00d D-46	deli
Box 68	atten atten I for u	iciar	in the past 12 months?	1 Live Birth 2 Fe 4 Pregnant at time o	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
о В	t the de by the stached	Physician/M	9 Unknown	9 Unknown						
О.	w requires that s been signed t should be det	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying cause given i	in Part I.	14		to the cause of death?
rds	requir	etec						1/4		Probably 4 Unknown
Division of Vital Records, P.O.	has has	Completed						24a. Was a autop perfor 1 Yes	sy prior t rmed? death	autopsy findings available o completion of cause of ? /es 2  No
<u>ta</u>	i <b>ician:</b> The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		LO41	of Death (Check			
<u> </u>	Physi this c	2	1 ☐ Yes 2 No H	1 Inpatient 2 28a. Date of injury	ER/Outpatient	1 3 🗆 DOA 📗 2			ence 6 Other (Sp	ecify) wo spud
0 0	ding I th. After funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury at work?  M 1 1 Yes	2 🗆 No	28a. Describe n	ow injury occurred	
isio	il or Attendi after death. Director: A d in by the fu	rtifi	3 Suicide 6 Could not be	28e. Place of Injury - At I					treet and Number or I	Rural Route Number,
<u>≤</u>	tal or irs afte al Dir		s'	building, etc. (Speci	ity)			City or Tow	n, State)	4
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2' Medical Examine	ian: To the best of my kno- er: On the basis of examinati Practioner: To the best of r	ion and/or investi	gation, in my opinion, d	leath occurred at	the time, date ar	nd place, and due to th	e cause(s) and manner stated.
	To the within To the Comit		29b. Signature and title of certifier	~~		29c, License nur  29c, License nur  V- CMa				
	1/		30. Name and address of person who col	mpleted cause of death (Ite	em 23a) (Type, Pr	rint)	, -			)
	H		AMON 7 Uts	HELES M	6701	N- Chai	rus S	1 TOW	20 M MI)	,
	Stat Registra	e ar	31. Date filed (Month, Day, Vear) FEB 1 2 2010	32. Registrar's Sign	parke	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:50 AM Keith **Physician** havies January 2010 /Medical a. Facility Name (If not institution, give streenand number)
Community Living Center\_ Loch Raven 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ F Months Days Hours 95 048-09-1417 AUG 23. 1914 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Hunt Valley Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Apt 458 21030 USA 400 Symphony Circle permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, it a Mental Economer must any Injury or other traumatic event, it a Mental Economer must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 TYes 2 XINo Specify Completed by Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Life Underwriter Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Beale Otis Ryan ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeri Hanly - Daughter 400 Symphony Cr. #458 Hunt Valley, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/28/10 4 Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility
Boone Funeral Home-East Chapel 21. Signature of Funeral Service Licensee Indiana 47715 <u>5330 Washington Avenue Evansville,</u> 23a. Parryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sease **Physician** ovonan /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 4 Unknown 1 ☐ Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy rmeg. 2 ∐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 **N**O Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Registrar

2

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

IM M.D.

Name and address of person who completed cause of death (tem 23a) (Type, Print) Loch Raven Boulevard Baltimore,

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-2. Date of Death Day 1. Decedent's Name (First, Middle, Last) PERLARY Year **Physician** 2010 3 DIAM Romansky Judith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ARUNDE CIEN BURNIE Anina BALTIMURE WASHINGTON MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 💢 F Yrs. July 28, 1944 Michigan Director 213-40-9598 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 PNo Director Anne Arundel Pasadena Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 U.S.A. Funeral 617 Eliot Drive 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify. þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 N/A Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fulton Randolph Laura Wilbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 617 Eliot Drive Pasadena, Maryland 21122 William R. Romansky, Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ី Burial 2 🗀 Cremation 3 🗀 Removal from State 2/13/2010 Glen Burnie, Maryland Glen Haven Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TERRONDSTUCAR /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 IZ No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

ipital or Attending Physician: The law requires that the death certificate be executed ours after death. In the confine the second of the confine that been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours a To the Funeral

with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be redified at

State Registrar (Check only one)

29b. Signature and title of certifie

NAPO

31. Date filed (Month, Day,

32. Registrar's

ted cause of death (Item 23a) (Type Print)

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2010

20161

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryiand		tificate of D				2010	03460
Phys			1. Decedent's Name (First, Middle Gordon H Spitte						2. Date of De	ath	201 gar	3. Time of Death 4:13 P M
	edic mine		4a. Facility Name (if not institution	n, give street and number)							County of Deatl	
/ 			Dove House  5. Social Security Number	6. Sex 7. Ao	e (In yrs. last	t hirthday)	Westmins	If Under 24 Hrs.	rroll	t I		
Fune Direct	tor		216-03-4907 Usual Residence of Decedent	<b>¾</b> ( <b>3</b> M 2 □ F	93	Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Months Days Hours Min.   (Months Day) Year)   10/30/1916					hplace (State or Foreign intry) MD
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death r items		Fun	11. Marital Status	12. Was Decedent I Armed Forces?		13. W	las Decedent of His Yes, specify Cuban		pecify Yes or No- o Rican, etc.)	1	4. Race - Amer Black, White	
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ind ;		To Be	17. Father's Name (First, Middle, I			18. Mother's Nan		Maiden S	urname)			
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, M6 nd2sh salth ar n27 is			Anna Spittel				g Address (Street an Skyline					Code)
<b>Baltimore, Maryland 21213-0036</b> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Examiner must be notified at			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 Removal from State	cerr	netery, crem	ition (Name of atory or other place)	•	Date 5 / 0.01.0		cation - City or	
altin rmit. Pe partme portan v injun	je	1	4 Donation 5 Other (Specify)  Messiah L.C. Cemetery 2/15/2010 Berett, MD  21. Signature of Enneyal Service Lie pase Burrrier Address of Facility Tuneral Home & Crematory									
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the death of the atter		Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	ath 5∐	Other (specify)				Month	Day Year
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II OI VILAI NEC ding Physician: The la h. After this certificate ha funeral director, page	1	e: 10	27. Manner of Death	28a. Date of inju	ent 2 ER	NOutpatient  b. Time of injury	3 □ DOA   28c. Injury a	4 Nursing H	ome 5 Resid			DOUE HOUSE
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To the Hospital or Attending Physician: The law requires that the death certification to the Hospital or Attending Physician: The law requires that the death certificate hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	:	Medical	(Check \ / 2 ∟ Medical E	Physician: To the best of xaminer: On the basis of e. Nurse Practioner: To the	xamination ar	nd/or investig	gation, in my opinion,	death occurred a	it the time, date a	nd place, a	and due to the ca	ause(s) and manner stated.
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	Physicia Medic			H. Spurrie	•	2. Date of Month Feb						Day Year 5 2010		ne of Death
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- "			Dove Ho 5. Social Security Number				Westminster						011	
	Funeral Director		218-28-8207	6. Sex 7. Age	e (In yrs. last birthday 77 Yrs.	Months	1 Year Days						Birthplace (State or Foreign Country) Maryland	
			Usual Residence of Decedent									1934 110	11110	TITO
	uyland I-f sho ied at	Director	10a. State 10b. County		10c. City, Town or I									de City Limits
	he Ma or 28¢		MD Balt:	Imore	Upperc	10f. Zip Code					100.0	Citizen of What C		Yes XX No
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	death items		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - Am		n,
36	after al", or xamii	d by	1 ☐ Never Married XXMar 3 ☐ Widowed 4 ☐ Divorced	ried 1XXYes 2	No	1 ☐ Yes XXNo Specify:				riiodri, oto.,		Black, Whi	te, etc. 'hite	
9	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decede	nt's Education	16a. Dec	edent's Usua	al Occupa	tion			T 16b.	Kind of Business		
21215-0036	within 72 giene. <b>er than "</b> ; the Med	omb	Elementary/Seconday (0-12)	st grade completed)  College (1-4 or 5	+) life.	e kind of wo DO NOT use	retired)					ommuni	catio	ns
2	filed within al Hygiene. d other tha went, the N	au l	17. Father's Name (First, Middle, L	act)	Sys	tems						Indu	stry	
au	be file ental   rked o	인	Franklin El	,	rrier					First, Middle, Marri				
Maryland	should be fill and Mental is marked aumatic eve		19a. Informant's Name/Relations	nip (Type, Print)		ling Address	(Street a					or Town, State, Zi	ip Code)	
∑	ind 2 see fealth im 27 her tra		Ora V. Spurr	ier / Wife						Rd. Up	per	co, MD	2115	55
Jore	permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition  XX Burial 2 ☐ Cremation	3  Removal from State	20b. Place of Disp Garris	osition (Nan ematory or o	ne of <b>LC</b> ther place	rest	2/1/	Date 6 /1 0		Location - City of Wings N		
Baltimore,	nit. Pa artmei ortant injury	1	4 Donation 5 Other (S		vetera	ins Ce	met	erv				eralCh		
Ba	Dep lmp any	s ()	Richard	June								ngs Mil		
	nysician/ Medical Examiner	er.	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	Ischer Consequence of): Conery Ate	de C	ardi	omyop VY	athy	r respiratory a	urrest,		Approxi Interval Onset a	imate Between and Death
	eath certificate be executed attending physician and for use as the burial-transit	fedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	с	consequence of);									
P.O. Box 68760	To the hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but the but the form of the form of the but t	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	Petal death 3	☐ Ectopic p☐ Other (sp		_				23d. Date of de Month	livery Day	Year
<u>Ч</u>	r requires that the de been signed by the should be detached	۾	Part II. Other significant condition	ns contributing to death bu	t not resulting in the	underlying o	ause give	n in Part I.		23e. Did 1	tobacco	use contribute to	the cause	of death?
rds.	een się rould t	ted	Diabere	5 Mean	/)					1 🗆	Yes 2	2 <b>1</b> No 3□P	robably 4	Unknown
Division of Vital Records,	Physician; The law rethis certificate has beral director, page 2 sh	Completed	25. Was case referred to medical	Нурез	:lipidemia					1 Yes	opsy ormed?	death?	topsy findin completion s 2 No	of cause of
<u>  (ta</u>	ysicia is cert directa	To Be	examiner? 1 ☐ Yes 2 💢 No	Hospital:	nt 2  ER/Outpatio	ent 3 🗆 DC	Othor	e of Deatl			donca	6 A Other (Spec	in Da	re toure
ō	ding Ph h. After th funeral		27. Manner of Death  1   Natural 5 □ Pendin	28a. Date of injury	/ 28b. Time o		Bc. Injury a			8d. Describe			illy)	ve jedan
loi	ttendi death. tor: A the fu	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation at he		М	1 🗆 Y	es 2 🗆	No					
<u>                                      </u>	or Attendi safter death Director: A d in by the f	Sel	4 Homicide determine		y - At home, farm, st (Spec <i>ify)</i>	reet, factory	office		2	28f. Location ( City or Tox		nd Number or Ru e)	ral Route No	umber,
	Io the Hospital or within 24 hours after To the Funeral Directory completed filled in b	Medical	29a. Certifier 1 Certifying	Physician: To the best of n	ny knowledge, death	occured at	the time, o	date and p	lace, and	due to the ca	ause(s) a	nd manner as sta	ated.	
;	the H hin 24 the Fi		only one) 3 Certifying	xaminer: On the basis of ex. Nurse Practioner: To the b	amination and/or inve	stigation, in r	noinian vr	, death occ	curred at t	the time, date a	and place	e, and due to the i	cause(s) and	manner stated.
	© 1½ to 100		29b. Signature and title of certifier	120 ME		29c.	License r	number	112		29d. Da	ate signed (Month	n, Day, Year)	7
J,	14.		30. Name and address of person v	the completed cause of de	ath (Item 23a) (Type	Print)		106	116		02	. 00	2016	
(	6,		D. Alexand	er Roc	ha MI	> 42	31 No	orthe	0000	15 Tr	Ha	2-08-	MD WID	21074
	Stat Registra	_	31. Date filed (Month, Day, Year)	2010 32. Projetrar	's Signature	barto	D							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 2010 12:55 AM 11. Stanley Stewart Seiler Februarv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Summerford Place Assisted Living Howard Co1umbia 8. Date of Birth (Month, Day, Year)

July 25, 1930 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex XIXM 2□ F Days 79 Ohio Director 405-36-2950 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, the "teolical Examiner must be notified at 1 □ Yes XXNo Director MD Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2010 Suffolk Rd. 21048 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. XXYes 2 No 1f Yes, Give 1953 Year or Dates: 1956 72 hours after XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 🗶 🕱 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Researcher Advertising I and 2 should be filed w Health and Mental Hygien om 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Seiler Elizabeth Lunsford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Edith Schuyler / Sister 2010 Suffolk Rd. Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 XXBurial 2 Cremation 3 Removal from State Garrison Forest Cem. 2/25/10 Owings Mills, MD 4 ☐ Donation 5 ☐ Cherr (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of For Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 chara 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6 years Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No page 2 certificate | 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify Assisted Living 1 ☐ Yes 2 ▼No 2 ER/Outpatient 3 DOA 1 | Inpatient this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

P.0. Division of Vital Records, Hospital or Attending Physician: 

State

MD

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D56531 Feb. 11, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Snowden River Pkwy. #301, Columbia, MD 21045

31. Date filed (Month, Day, Year) FEB 1 2 2010

4 Homicide

(Check only

29b. Signature and title of certifier

Harry Li,

29a. Certifier

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #9 per Fh g900 2/12/10 TT
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of		, ,	ene <sub>LNo.</sub> 2 N   1	031.63		
	Physici	an	1. Decedent's Name (First, Middle	, Last)				2. Date of Death Month	Day Year	3. Time of Death		
	/Medic		Alice Stepan					February	5, 2010	) 5:35 p <sup>M</sup>		
	Examin	er	4a. Facility Name (If not institution				or Location of Death		4c. County of Death			
1 market			Laurel Regiona.  5. Social Security Number		o (la una la at hirthda)	Laurel  // If Under 1 Year	If Under 24 Hrs.		Prince Ge			
и	Funeral Director		384-12-5914 1□ M 2⊠ F 86 Yrs. Months Days Hours Min									
	yland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
	Ba-f s	Director	MD Prince	George	Laurel					1 ☐ Yes 2 🔯 No		
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What C	ountry?		
	ath w	ral	6500 Old Sandy			20707		US	A			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygene. I Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Madical Examinar must be realthed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed Forces?	1 ☐Yes 2X No If Yes, Give		Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □Yes ※□ No Specify:			erican Indian, ie, etc. nite		
5-0	72 ho	eted	15. Decedent' (Specify only highes:	s Education	16a. Dec	edent's Usual Occup	pation	ing 16	b. Kind of Business	/Industry		
21	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retire	d)					
121	led w Hygie her ti nt, it		17 Falbaria Nama /First Middle /	2	Para	legal	10 11-15-16-16-16-16-16-16-16-16-16-16-16-16-16-		idan Cumana)			
anc	2 should be filed within and Mental Hygiene. is marked other than "is raumatic event, It e Mental Mental and a should be shoul	Be	17. Father's Name (First, Middle, L Antonio Sgarla				Jenny Mo	e <i>(First, Middle, M</i> a rabito	iden Surname)			
Z	hould nd Me mark matte	ရ	19a. Informant's Name/Relationsh		10h Mai	ling Address (Street	1		City or Town State	Zin Cadal		
	and 2 s ealth ar n 27 is ner trau		Karen F. Porter			Lambada 1				Zip Code)		
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □ Removal from State		position (Name of ematory or other place			c. Location - City or	Town, State		
Him	arth arth		4 ☐ Donation 5 ☑ Other (Sp. 21. Signature of Funeral Service L	ecify)Entombmen		ction Cem 22. Name and Addre			inton, MI			
ä	permi Depa Impo any ir		I gitten Steles		M01053	313 Talbo	tt Ave.,	Laurel, M	D 20707	7 1 111		
П			23a. Pax 1. Enter the disease, or o shock, or heart failure. List of	complications that caused only one cause on each li	I the death. Do not en ne.	nter the mode of dyin	ng, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cardio-	respirato	ry Arrest				Onset and Death		
20	/Medical Examiner		resulting in death)	111	a consequence of):							
		-	Sequentially list conditions,	b. Septece	emla a consequence of:							
	uted d insit	Examiner	Sequentially list conditions, it is cause. Enter Underlying Cause (Disease or injury	Bactere								
Ć,	exec in and ial-tra	Еха	that initiated events resulting in death) Last	C	a consequence of):		·					
68760,	rificate be executed ng physician and as the burial-transit	edical	<u>d.</u>									
			IF FEMALE:				_					
O. Box	requires that the death cert een signed by the attendin nould be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death 3	☐ Ectopic pregnand	ey .		23d. Date of de Month	olivery Day Year		
S, P.	res that signed b be deta	by Pt	Part II. Other significant condition	ns contributing to death b	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?		
ord	w require been si should b			V-211L-1			<del></del>	1 ☐ Yes	2 □ No 3 □ F	robably 4 Inknown		
Division of Vital Records,	The law ate has b page 2 st	Completed						24a. Was an autopsy performe 1 □ Yes 24	d? prior to death?	utopsy findings available completion of cause of		
Vit.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		h (Check only one)	-			
o	Phys	5	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Nospital. 1 Inpatie	ent 2 ER/Outpatie		4 LI Nursing Ho	ome 5 Residence		ecify)		
o	ding Ph. h. After thi funeral	tion	1 Natural 5 Pending 2 Accident investiga	(Month, Da		Wor	k?  Yes 2□No	280. Describe now	injury occurred			
visi	r Attending er death. rector: After by the fune	Certification:	3 Suicide 6 Could not determine		ury - At home, farm, s c. <i>(Specify)</i>		103 2 10	28f. Location (Stree City or Town, S	et and Number or Fi	ural Route Number,		
	Hospital or 24 hours afte Funeral Dir tely filled in											
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  ***Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner sta	f examination and/or i	investigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, date	ise(s) and manner a e and place, and du	e to the cause(s)		
	vithii To th	ž	29b. Signature and title of certifier	and TA	11	29c. Licens	se number	29d	. Date signed (Mon	th, Day, Year)		
			•	my I A	5	D6093	36	Fe	bruary 6,	2010		
	į		30. Name and address of person was Abdul Mar-Tak, MI	·	Dugon Boa	a Taurol	, MD 2070	7				
	Sta	te	31. Date filed (Marie By Yea)		ar's Signature	all laurer						
	Registra	ar	ICUIA	LUIU MEREN	- 12. 14.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29a & 30 per DVR g900 2/12/10 TT

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	Otate of Maryle		ertificate of		Re	g. No. 2	10	03464	
	Physici	an	1. Decedent's Name (First, Middle, I	•	-			2. Date of Death Month February		Year	3. Time of Death 18:54 M	
	/Medio		WALTER A  4a. Facility Name (If not institution, g	MBROSE SUSIN		4h City Town o	r Location of Death	rebruary	4c. County o		18:54 M	
	Examir	ıer	Anne Arundel Me							Anne Arundel		
i	Funeral Director				rs. last birthday Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, May 17,	Year) 1956	9. Birthp Cour MD	lace (State or Foreign try)	
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limits	
	Aaryle f sho	ō	MD Anne A		Crownsv						1√GYes 2□No	
	the 128a-	Director	10e. Street and Number	runder	JEOWIIS V.	10f. Zip Code		10	g. Citizen of WI	hat Coun		
	3a or		818 Whitewood T	rail		21032			J.S.A.			
	death	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin? (Spo	ecify Yes or No-			an Indian,	
5-0036	n 72 hours after death with the Maryland "matural", or items 23a or 28a-f show golcal Examinat rust be notified at	þ	1 ☐ Never Married 2XXXMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 XXIo If Yes, Give Year or Dates:		1 □Yes 2XXNo	Specify:	nican, etc.)	Specify:	, White, o		
<u>ה</u>	"natu	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of worki	ing 1	6b. Kind of Bus	iness/Ind	dustry	
7	filed within Hygiene. other than "	ш	Elementary/Secondary (0-12) Grade 12	College (1-4or 5+)		er/Operato			Office :	Eaui	pment	
ס ס	be filed htal Hygi ed other event, I	Be C	17. Father's Name (First, Middle, La	st)	0.011	JI/ OPCIAGO	18. Mother's Name				<u> </u>	
<u>a</u> n	lid be fental rked d	To B	Harry Ambrose S	usini			Ruth Shir	rley John	nson			
ary	2 should be and Menta is marked is raumatic ev	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street	and Number or Rura	al Route Number,	City or Town, S	State, Zip	Code)	
o, E	and 2 ealth n 27 i		Deborah Ann Sus			Whitewood		rownsvil	le, Mar	ylan	d 21032	
o e	jes 1 t of He if iten		20a. Method of Disposition 1√Burial 2 ☐ Cremation 3	☐ Removal from State	p. Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date 2	0c. Location - C	City or To	wn, State	
aitimor	. Pag tment tant: jury o		4 Donation 5 Dother (Spe	cify) St		's Cemetey			Laurel,	Mar	yland	
ga	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Lic			2. Name and Addre				7	00505	
			23a. Part 1. Enter the disease, or co	M00770		313 Talbot				and	20707	
	Newstein	10	shock, or heart failure. List on Immediate Cause (Final	If one cause on each line.		HTORY	19411 Cl		J.,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons		7	1-11/104	re				
	Examiner			B	RADY	CAPDI	A.					
	± 0	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equencé of).		2 . 1	. 4.3	12 1			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	PIRA	PN	eumo	NIT				
Ď,	icate be executed physician and the burial-transit		resulting in death) cast	Due to (or as a cons	equence of):	4770N	BIFF	7/103	-			
00/00	icate physi the t	Medical	<b>'</b>	d		C7 - ,L .	1) 000					
X	certific nding p use as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg					23d. Date	of delive	erv	
6	death e atte	iclar	in the past 12 months? 1 □Yes 2 □No	1 ☐ Live birth 2 ☐ Fo 4 ☐ Pregnant at time of		☐ Ectopic pregnanc ☐ Other (specify) _	у		Mon		Day Year	
5	t the by the	Physician/	9 ☐ Unknown	9 ☐ Unknown								
'n	es tha gned oe det	by P	Part II. Other significant conditions	contributing to death but not r	resulting in the u	underlying cause give	en in Part I.	23e. Did toba	23e. Did tobacco use contribute to the cause of death?			
ecords,	equire sen si ould t	ted	Hep C					1 ☐ Yes	2 □ No :	3 ☐ Prob	ably 4 Unknown	
ວັ	law r nas be 2 sh	ple	Lux ce	recores				24a. Was an autopsy	24b. W	ere auto	psy findings available mpletion of cause of	
E	: The cate by page	Completed	Stope IV	- liner co	enco	V		perform 1 □Yes 2	ed? de	eath? □Yes	2 No	
אונשו	ician certifi ector	æ	25. Was case referred to medical examiner?	Hospital:		ort 3 Cl DOA Oth	26. Place of Death	(Check only one	)		•	
5	Phys r this ral dir	욘	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	☐ ER/Outpatie	SIL 3 LI DOA	4 LI Nursing Ho	me 5 Resider			y)	
5	ding th. Afte fune	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day, Year,	) Injury	Worl	k? Yes 2 □No	20d. Describe nov	v Injury occurre	u		
VISION	Atten	lica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - Al	l t home, farm, st			28f. Location (Stre	eet and Numbe	r or Rura	Il Route Number,	
5	al or s afte al Dir	Certification: To	4 ☐ Homicide determine	building, etc. (Spe	эспу)			City or Town,	State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 X Certifying (Check only one) 2  Medical Ex	Physician: To the best of my laminer: On the basis of exam and manner stated.	knowledge, dea iination and/or ii	th occurred at the tin nvestigation, in my o	me, date and place, pinion, death occuri	and due to the ca red at the time, da	use(s) and mar te and place, a	nner as s nd due to	stated. the cause(s)	
	with To t	Σ	29b. Signature and title of certifier	poper te	1807	29c. Licens			d. Date signed $2/7$	(Month,	Day, Year) )	
(	9)		30. Name and ddress of pe son wh	o completed cause of death (I	tem 23a) (Type,	Print)	mre-	1 .11-			3	
_ \		1 1	Judy Joseph-Herbe	ert, MD		2001	MEDICA	TO DES	7 H10	NAPI	115,10, 214	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrary Sig	gnature	fra de	9					
DHA	H 17 Rev 1/2	- 4	LER.	ocompleted cause of death (in ert, MD 32. Registrary Signature)	un p.	Marie						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 2010 Saxon  $\mathbf{P}^\mathsf{M}$ Mary 7:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 19<u>13</u> 1 🗆 M 2 💢 F Months Days Hours Min. Virginia Director 96 Mar. 080-03-1721 Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗡 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: If Yes, Give Specify: Black 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home æ Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Sydnor Fannie Bet Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Flintlock Dr., Lansdale, PA 19446 Monroe Saxon (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☒ Bural 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ ponation 5 ☐ Other (Specify) cemetery, crematory or other place) Millstone Bapt. Church 2/13/2010 Nathalie, VA 21. Sign ture of F neral Service Licen-22. Name and Address of Facility
Jeffress Funeral Home 2000 N. Main St., South Boston, VA 24592 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final EREBROVASCULAR ACCIDENT Onset and Death Physician disease or condition resulting in death) Medical DEMENTIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? injury 5 Pending within 24 hours after death, To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

カカ

W.

State Registrar (Check

only on

ath (Nem 23a) (Type Print) ONTROSERD, ROCKVILLE, MD 20852 32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pranticiper: To the basis of my line will age doubt occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1 3 5 4 36

29d. Date signed (Month, Day, Year) FEBRUARY 05, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend itemstate of Maryland & Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year :35/M Physician/ STURT FEBRUARU 2010 EDWARD Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A BALTIMORE BAYVIEW MEDICAL CENTE JOHNS HOAKINS 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Year)
July 10,1930 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Director 212-26-5702 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at by Funeral Director **Dundalk** 1 Yes 2 X No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 7877 Harold Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Air Force Aircraft Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve 2 Kathleen O'Connor Joseph Sturtz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1574 Hallwood Court Crofton, Maryland 21114 Tracy S. Webster (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/<del>15</del>/2010 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Dother (Specify) Service Life 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of F <u>Maryland</u> 7922 Wise Ave. Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC DAYS Physician/ SHOCH disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** DIFF COLITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MENINGITIS autopsy performed? 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? filled in by the funeral director, Be 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a RES -000 FEGRU ARY and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AJENUE BALTIMORE MD 21224 haron 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Year Month Feb. Day Physician/ Agatha Ruth Shaver 6 12:16A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Timonium Stella Maris Hospice Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Yea Days 1 M 2 😾 7,1918 91 Sept. Virginia Director 214-44-4088 West Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director Edgemere MD 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States 7341 Geise Avenue Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 8 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosa Miller Miller John Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Maryland 21219 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 7341 Geise Ave. Mrs. Donna Myers (Daughter) injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 2/12/2010 Towson, Maryland Hilltop Service Corp. 22. Name and Address of Facility
Unda-Ruck Funeral Home of Dundalk, Inc.
2022 Wise Ave. Dundalk, Maryland 21222 Signar 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PARKINSON'S DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. E. tel Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificat Yes 2X 25. Was case referred to medical examiner?
1 ☐ Yes 2 🗶 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JACKIĖ JONES

31. Date filed (Month, Day, Year)

**CRNP** 

FEBRUARY

SHAVE

AGATHA

2300 DULANEY VALLEY RD.

TIMONIUM,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ <sup>™</sup>2010 Ruth Elizabeth Sorandes February 5 7:05 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Meadows Retirement Community Glen Arm Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min. February 213-82-0958 88 Director Maryland 1921 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Baltimore 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9530 Hickory Falls Way 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Dolan Philip Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9530 Hickory Falls Way Baltimore Maryland 21236 Jone Wingfield/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gardens of Faith Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/12/10 Baltimore Maryland 21. Signature of Funeral Service Licensee 122. Name and Address of Facility Leonard J. Ruck Tinc 5305 Harrord Road Baltimore Mayrland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death HOURS shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician PROBABLE MUDCARBIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy perform Director: After this certificate Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED LIVIN 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? death. 1 Yes Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) within 24 hours after c

To the Funeral Direct
completed filled in by determined filled Medical 1 👺 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D64395 FEBRUARY 5. 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMANIMO 6701 NOUMPLES ST, SMITE 4105 BALTIMERE, MA 21204 State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Dav 5 7010 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Dec 8, 1974 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Months Hours **Funeral** 1 X M 2 □ F Texas 35 464-39-4414 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No notified at Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21224 316 Kane Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No 11. Marital Status Black, White, etc Examiner 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No 21215-0036 Specify: White ò 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) er than "natur , the Medical College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical Physician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Agnes Theresa Harbus John Charles Susil ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Father-MD 20852 11418 Rolling House Road, N. Bethesda, in-Law George S. Weigel, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 2/16/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signarye of Fundal Serves Lidebase

Martin U. Lawson MITCHELL WIEGEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonard **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Division of Vital Records, 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: director, Be examiner? Other: 4 Nursing Home Hospital: Inpatient 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 Yes မ this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury 5 Pending investigation 1 Natural 1 Tes 2 🗌 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined City or Town, State) 4 Homicide ithin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical (check only 29d. Date signed (Month, Day, Year) within To the 29c. License number 29b. Signature and title of certifier P 23748 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JAGANA

DHMH 17 Rev 1/2001

State

Registrar

RAJANI

31. Date filed (Month, Day, Year)

2 2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Day Physician/ Brady Sinclair 2010 4:15 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12907 Dover Road Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 □XF Il Thois 209-36-9491 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 🗆 Yes 2 🗆 No Fla. Indian River Vero Beach 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 23a 32963 U.S.A. 9220 Autumn Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Ş 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) af Hygiene. Elementary/Seconday (0-12) the homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Mary Shodron Edward J. Brady 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) |12907 Dover Road Reisterstown, Maryland 21136 James Sinclair/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gdns. 2/9/2010 |Timonium,Maryland 4 Donation 5 X Other (Spentombment 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. . Signature of Function Licen 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 2 Mems disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury g physician and is the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

NOYTH BALTIM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 5 per FH, 6900, 2 26, 2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 08 20°TO Robert Α. Suchy 4:40 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Sinai Hospital 212-30-1273 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours Min June 7, 1934 Maryrand Director 75 Usual Residence of Decedent shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7824 Ellenham Rd. 21204 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) +4 Civil Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Suchy Mary Daniloski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Cecily Suchy/ Wife 7824 Ellenham Rd. Baltimore, Md. 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. 2-12-10 4 ☐ Donation 5 ☐ Other (Specify) Towson, Md. 21. Signature of Funeral <sup>22. Name and</sup> Ruck of Towson Funeral Home, 1050 York Rd. Towson, Md. Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or a's a consequence of): Examiner Securificity list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conse or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a conseque ω resulting in death) Last nce of): attending physician for use as the buna Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death signed by the a 2 No 9 🗌 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy death? 1 🗌 Yes 2 🗷 No this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 Inpatient ER/Outpatient 3 DOA After thi funeral 27. Memer of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? Accident 1 Tes 2 No Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the f 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🖒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10:26 PM fred Sain 02 2010 1 Win /Medical 4a. Facility Name (If not institution, give street and number)
ShockTicuma Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore Hma 8. Date of Birth (Month, Day, Year) Oct. 3, 1931 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F Min. North Carolina 244-40-9958 78 Oct. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Midical Examinar qual be natified at 1 ☐ Yes 2 No Director Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21122 4004 Belle of Georgia Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " College (1-4or 5+) Self-Employed Drywall Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eula Ress C1yde Sain မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 4004 Belle of Georgia Avenue, Pasadena, Maryland 21122 JoAnn Sain (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Mem. Park 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Feb.10, 2010 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral-Service License McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition /Medical a consequence of): Du to (or 1 23 10 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tra Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) miner examiner? 1XXYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, ) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) 1 Natural 5 ☐ Pending investigation Fall from Ó 123 10 PM 1E ace of Injury - At home, farm, street, factory, office pulding, etc. (Specify) 2 Accident 1 ☐ Yes 2 XNo 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route City or Town, State)

Georgy AN

And due to the cause(s) and manner as stated. 28e. P (Street and Number or Rural Route Number, determined Hame 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 0+

Registrar

State

22

Sorth Greene Street Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sommerk

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ STABLEY Feb. 8, KAREN L. 9 2010 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 105 West Hughes Street Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 D M 2 X F Months Hours Min. 196-44-5825 56 **Director** Pennsylvania 22 Anr Usual Residence of Decedent 28a-f show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shor event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Maryland N/A 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 105 West Hughes Street 21230 USA Page 1 and 2 should be filed within 72 hours after death vert of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces ☐ Yes 2 🗓 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working Baltimore Sun Newspaper Elementary/Seconday (0-12) College (1-4 or 5+) Journalist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Leona Louise Savits Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gisriel (Husband) 105 West Hughes St., Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other p. 20a. Method of Disposition 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State Glen Burnie, Maryland Atlantic Crematory, LLC 2/10/10 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physiciani esophagea caranoma disease or condition resulting in death) mon4hs Medical Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 X No death? 1 Yes Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27, Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

within 24 hor To the Fune completed fi

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

the

DHMH 17 Rev 7/2009

where his

32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

60203

29d. Date signed (Month, Day, Year)

ebruari

2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Rosalyn Juergens, no 1650 Orleans Street Johns Hopkins CRBI-G93 Baltimore, Maryland

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9, **Physician** 2010 2:10 A M February Santana Emma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel <u>Millersville</u> Knollwood Manor Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🛚 F Months Days Yrs. 4,1943 West Virginia Sept. Director 235-68-0157 66 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Catonsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21228 Completed by Funeral 3752 Beninzer Road death \ 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 N If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Wivorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hospital 12 Lab. Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fili Department of Health and Mental Hi Important: If Item 27 Is marked oth any Injury or other traumatic event Be Ambrose Aulabaugh Emma ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 221 Oak Drive Pasadena, Maryland 21122 Ruth M. Gibel (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/09/10 Atlantic Cremation Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCIEROTIC CALDIOVASCULAR 1) (SEASIS Y GARS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

29c. License number

031136

9005 KILBRIDE RD, BALTIMORES, MD 21236

29d. Date signed (Month, Day, Year)

FEBRUARY 9, 2010

and manner stated.

(M)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALLACE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Februar Physician/ 52 Lynn Willis Tenny 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Washington County Hospital Hagerstown 8. Date of Birth Nov. 18, 1929 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min Hours 1**x**xM 2 □ F New York Director 064-22-5274 80 Usual Residence of Decedent 28a-f show 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 🛛 No Boonsboro Washington MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21713 6169 Old National Pike death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★ Yes 2 □ No 1947 If Yes, Give 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify white Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Safeway store 12th Grocery Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlotte Cooper Lynn W. Tenny, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a :: If item 27 is 21776 New Windsor, MD Barbara Bierman daughter 4024 Roop Road Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2xxCremation 3 Removal from State South Carroll Crematory Feb.5, 2010 winfield, md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature V Funeral Service Licensee 22. Name and Address of Facility Furrier-Queen Funeral Home & Crematory 1212 W. Old Liberty Road Winfield, M 21784 art 1. E ter the disease, or complications that caused the death. Do not shock, o heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Im ediate ause (Final di base or ondition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or impury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 🗆 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death \_ Yes been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed this certificate 1 ☐ Yes 2 ☐ No After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA မ Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ti 29d. Date signed (Month, Day, Year) 006717

Registrar

DHMH 17 Rev 7/2009

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32. Registrar's

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31. Date file

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ M Harvey Allen Teets, Feb 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3032 Walnut St. Manchester Carroll If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** May IO, 1940 Hours 1 ₹ M 2 □ F Maryland 213-36-6930 69 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the fitter 275 is marked of other than "natural", or items 23a or 28a-f show ant: If item 27 is marked of other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Carroll 1 Yes 2X No Maryland Manchester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3032 Walnut St. 21102 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Upholstery Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Allen Teets Margaret Winebrenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia B. Teets - wife 3032 Walnut St. Manchester, MD. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Feb. 12,2010 Baltimore, MD. 22. Name and Address of Facility Eckhardt Funeral Chapel P. 21. Signature of Funeral Service Licenses Hartel 3296 Charmil Dr. Manchester, MD. 21102 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2HRONIC OBSTRUCTURE Physician 10 Manaca acon Jueau disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 2 🗆 No 24 hours after death. **e Funeral Director:** After this certificate has been signed by the a fetneral director. After this certificate has been signed by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No Yes 2 0 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by th 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🕇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

tramas K. Cole

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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We Smind STEC

SDIVER AVE

29d. Date signed (Month, Day, Year)

2/12/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

uan Tucker		State of Maryland / Department of Health and Mental F  Certificate of Death	Hygiene	2010	03477
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last)  Tucker	2. Date of Deat Month February 3		3. Time of Death 0930 hrs
		4a. Facilify Name (if not institution, give street and number)  University Hospital  4b. City, Town, or Location of Dear  Baltimore		4c. County of Death	n -
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi	_	76 Foreign	rthplace (State or gn MD ountry)
he Maryland or 28a-f show any fied at once.	Director	Usual Residence of Decedent	10	0g. Citizen of What Cou	10d. Inside City Limits  XXYes 2 No  ntry?
with the M is 23a or 2 e notified		119 N. Fremont Avenue 21201  11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$\frac{1}{3} \text{ Was Decedent of Hispanic Origin?}\$}\$		USA - 14. Race - Amer	ican Indian, Black,
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerlock 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		White, etcA  Specify: Ame  16b. Kind of Business/	
036 thin 72 hour ne. r than "natu ledical Exar	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  11th Grade NA Laborer  Laborer	etired)	varies tr	·
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical	မ္က	Jeffrey Tucker Patrio		terkin	
e, MD 2.  I and 2 should Health and M. item 27 is mar	ဥ	19a. Informant's Name/Relationship (Type, Print)  TYREKA Timmons Tucker-Wife 119 N. Fremont Av  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Rural Route Num ZENUE B	altimore,	
Baltimore, permit. Pages 1 an Department of Her Important; If ite		1 Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 02	2-11-10	Lansdown	e, MD
		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Wy  38 N. Gilmor S  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	treet B	altimore,	P.A. MD 21217
Physician Wedical Examiner		failure. List only one cause on each <sup>§</sup> line.  Immediate Cause (Final disease a, Multiple Gunshot Wounds	or respiratory arre	est, SHOOK, OF Heart	Between Onset and Death
	e	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
ed	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last   Due to (or as a consequence of):  d.		2	
0, Co.	edical	UNPENDED AMENDED		Lood Date of dating	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bunial.	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	23d. Date of deliver Month	y Day <b>Y</b> ear
P.O. I signed by the be detache	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
Division of Vital Records, tal or Attending Physician; The law requires after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should to the funeral director.	Completed		24a. Was a autops perfor 1 ✓ Yes 2	sy prior to o med? death?	utopsy findings available completion of cause of
Vital Rec hysician; The I this certificate	o Be C	25 Was case referred to medical examiner?  1 Ves 2 No   26 Place of Death (Check Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, 4 Nursell		Residence 6 Othe	r:
ion of \ tending Phy eath. tor: After the	-1	27. Manner of Death 1 Natural 5 Pending 28a Date of Injury (Month Day Year) Feb 3, 2010 28b Time of Injury 28c Injury at Work? 1 Yes 2 ✓ No	28d. Describe h Subject shot	now injury occurred	
Division pital or Attenc ours after death eral Director; filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street	or Town, St	Street and Number or Rutate) nondson Avenue, Ba	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
6 1 2 1	ğ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d Date signed (Mo February 4, 2010	
4		30 Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	)1		
St	ate	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature . Sauce			

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registra Certificate of Death Reg. No Jate c Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day S Month EDUARY 8 av. - 4c. County of Death Thomas **Physician** 2:45 AM ANIMON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number **Funeral** Days Hours 218-31-582 pano march Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Director 12 no K injury or other traumatic event, the Medical Examiner must be notified na. Anne 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ō Zi items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 'natural", or Specify þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seeondary (0-12) College (1-4 or 5+ Department of Health and Mental Hygiene. Important: If item 27 is marked other than 16 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be thon 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brooklyn, MD 206 Jacquelino Old 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State d 5 Other (Specify) ☐ Donation 22. Name and Address of Facility 21. Signature any md.aid the tipe is ease, in complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, hear failure. List only one cause on each line. Approximate Interval Between Parl 1. izn Onset and Death Immediat Cause (Final Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner etastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-transi attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 - Ectopic pregnancy completely filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. 2 No 3 Probably 1 🗌 Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death.

Funeral Director: After this certificate has 2 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital: 2 No 1 Elinpatient 2 ER/Outpatient 3 🗆 DOA 1 Yes မ 28a. Date of Injury (Month, Day Year) 28b. Time o 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 FT Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, 4 - Homicide Cify or Town, State) the Hospital 29a, Certifie 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Cror 600 North Wolfe St, Baltimore, MD, 21287 hael Mc Conor 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 0930 AM 26 P Harden Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HARBOR Baltinare 0 Z N/A Birthplace (State or Foreign Country)
 MD 8. Date of Birth
July 27 1937 5. Social Security Numbe Age (In yrs, last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Min. Hours 1 ☑ M 2 □ F 72 Yrs. Director 219-32-3876 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Governor Court Apt. C 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electronic Technician Westinghouse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen Guzick Russell C. Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21061 Governor Court, Apt. C, Glen Burnie, Anna M. Tucker (spouse) 108 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date Feb 13 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State Baltimore, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the disease, or complicate shock, or heart failure. List only one called the Cause (Final 23a, Part 1, Enter the hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Acate Physician/ MINITED disease or condition resulting in death) Medical Due to (or as a consequence of Examiner theras elecat Successfields that ricestifficant Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death isigned by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 performed? Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 မ ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29c. License number 29b. Signature and title of certifie è 8 MYSICIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n Hundrer Street

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene  1-State Registrar  Certificate of Death Reg. No. 2 0 1 0 0 3 1 8 6									
1 December Name (First Middle Loot)										
	Physicia Medic		Betty wickenho	Jeen		Month Feb.	06, 2010 8:30A M			
	Examin		4a. Facility Name (if not institution, give street and nu		4b. City, Town, or Location of	Death	4c. County of Death			
	Funeral		Future Care Irving 5. Social Security Number 6. Sex	ton 7. Age (In yrs. last birtho	Baltimore    Baltimore   Balti	4 Hrs. 8. Date of Birth	NA  9. Birthplace (State or Foreign			
	Director		232-42-2751 <sup>1□ M 2</sup> X F	82 Y	Months Days Hours	Min. (Month, Pay, Yo 06-04-	S. Birtiplace (State of Poreign Country) VA.			
7	at at	r.	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town of	or Location	,	10d. Inside City Limits			
tondor	aryan Ba-f sl Lified	ecto	MD NA	Balti			1 Yes 2 □ No			
d d	a or 28	I Dir	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?			
th veriff	ms 23	Funeral Director	22 S. Athol Avenue		21229		USA			
Maryland 21215-0036	the mean warm regions are death will the weayland the heat Hygiene.  Red other than "natural", or items 23a or 28a-f show tic event, the Medical Examiner must be notified at	by	Armed F	orces? 2 XNo ive	<ul><li>13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,</li><li>1 Yes 2 No Specify:</li></ul>	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Causion			
	"natu	plet	15. Decedent's Education (Specify only highest grade completed	d) i (0	ecedent's Usual Occupation Give kind of work done during most o	of working	6b. Kind of Business Industry			
727	r than	Completed	Elementary/Seconday (0-12) College (	1~4 Or 5+)	fe. DO NOT use retired) Actory worker	G	Glass Company			
בישון השלייו	al Hyg d othe vent.	Be	17. Father's Name (First, Middle, Last) unk			's Name (First, Middle, Mai				
ylar	Ment narke natic e	욘								
Na Na	th and Meni		19a. Informant's Name/Relationship (Type, Print) Freida A. Jones				ity or Town, State, Zip Code) MD. Suite #300 Balto.			
re,	of Hea		20a. Method of Disposition	20b. Place of D	Disposition (Name of	Date 20	Oc. Location - City or Town, State			
Baltimore,	ment care		1 X Burial 2 ☐ Cremation 3 ☐ Removal fror 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Z	crematory or other place) Lion Cem. 0	2-12-10   I	ansdowne, MD			
Ban	permit: rage rand s si Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	•	eral Home P.A. altimore, MD 21217			
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	caused the death. Do not	enter the mode of dying, such as ca	ardiac or respiratory arrest,	Approximate Interval Between			
	rysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	lassalie		imory	MENDW Onset and Death			
	xaminer			(or as a consequence of)		0				
77	#	Examiner	cause. Enter Underlying	(or as a consequence of)						
ecuted	and I-trans	Exan	Cause (Disease or iinjury that initiated events c. Due to Due to	(or as a consequence of)						
<b>5</b> 6 6	physician and the burial-transit	edical	d.							
<b>68/60</b>	ng phy as the	Med	IF FEMALE:							
<b>BOX 5</b>	ittendir or use	ian/	23b. Was decedent pregnant in the past 12 months?	tcome of pregnancy Birth 2 Fetal death			23d. Date of delivery  Month Day Year			
je de	y the a	Physician/M	1  Yes 2 No 4 Pre 9 Unknown 9 Unk		5 U Other (specify)		WORTH Day Tour			
That the table of the table of the table of the table of	gned b	by P	Part II. Other significant conditions contributing to	death but not resulting in t	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?			
<b>Kecords,</b> The law requires	een sig	ted	No ru fleway 20	The control of the co		1 \[ \sum \text{Yes}	2 No 3 Probably 4 Unknown			
law re	has b	Completed	Aseus			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?			
Ž į	ifficate or, pag		25. Was case referred to medical		26. Place of Death	performe	No 1 ☐ Yes 2 ☐ No			
VITAI Vsician:	is cer direct	To Be	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/Outp	Othori	ing Home 5 Residence	te 6 Other (Specify)			
Ing P	The After the funeral	ate:	1 1 Natural 3 1 Ferfuling	e of injury 28b. Tim oth, Day, Year) inju	ne of 28c. Injury at work?	28d. Describe how				
SIO	r death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e of Injury - At home, farm	M 1 Yes 2 N		et and Number or Rural Route Number.			
<b>DIVISION</b> tal or Attendir	rs after al Dire ed in b			ling, etc. (Specify)	,,,	City or Town, S				
Hospi	24 hou Funer	edical	(Check 2 ☐ Medical Examiner: On the ba	isis of examination and/or in	ath occured at the time, date and planvestigation, in my opinion, death occur	irred at the time, date and p	place, and due to the cause(s) and manner stated.			
To the	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ž	only one) 3 ☐ Certifying Nurse Practioner  29b. Signature and title of certifier	to the best of my knowled	ge, death occurred at the time, date a  29c. License number	nd place, and due to the ca	use(s) and manner as stated.  Date signed (Month, Day, Year)			
			May Zuca		D391	27	02/09/2010			
	Ì		30. Name and address of person who completed cau	se of death (Item 23a) (Typ	V - Gulau St	Ballin	080MN 212m1			
	Stat	e	31. Date filed (Month, Day, Year) 32.	egistrar's Signature	hadd	-01/10	20.			
	Registra	ır	FEB 1 2 2010   🔏	eners B.	4 ance					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / Department of Health and M	lental Hygien	e <sub>anin</sub> n	21.01
	_		State Registrar	Certificate of Death	Reg. N	10.ZUIU U	3401
	Physicia Medic		1. Decedent's Name (First, Middle, Last	Howard WALKER JA.	2. Date of Death Month O2	41/	Time of Death  3:17 M
	Examir		4a. Facility Name (if not institution, give s  BALTIMORE VA M		4.	c. County of Death	
Ī	Funeral Director		5. Social Security Number 6. Sec	7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (S Country)	State or Foreign
-	*		Usual Residence of Decedent		marin 6,1	10-(1	57000
	Maryland Ba-f show	rector	10a. State 10b. County	A Backmore			side City Limits
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 587 S. B.C.	echneur St. 10f. Zip Code 21229	10g. C	Citizen of What Country?	
336	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1	cify Yes or No- lican, etc.)	14. Race - American Indi Black, White, etc- Specify:	ian,
21215-0036	n 72 hours e. ian "natur Medical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Seconday (0-12)			Kind of Business Industry	+ (
nd 21	iled within Il Hygiene. I other tha vent, the I	Be	17. Father's Name (First, Middle, Last)	N/A H-Operator	(First, Middle, Maiden	Foun	4 Co.
Maryland	should be fil and Mental is marked aumatic ev	To	19a, Informant's Name/Relationship (Type	w. Walker Lottie	mcr	Fadden	
	and 2 sh Health ar tem 27 is		Carolan Lee		Rd · Bal	4	21215
Baltimore,	O +- 1-		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ I	20b. Place of Disposition (Name of		Location - City or Town, Sta	
Ĭ	t. Page 1 tment of rtant: If it ijury or o		4 Donation 5 Other (Specify)	Varison torest 2-17	-10 00	WINGS, M	ILLS,
Ba	permit. Page Department Important: I any injury o	5 9	21. Signatury of Funeral Service Lick se	bary f. march	F.H. 12	salto no	, 21229
			23a. Part . Inter the disease, or compleshed or heart failure. List only one	cations that caused the death. Do not enter the mode of dying, such as cardiac or e cause on each line.	respiratory arrest,	Interv	oximate al Between
F	nysician/ Medical	i i	Immedia de Cause (Final diseas de condition resulting in death)	PNEUMONFA		Onset	t and Death
	Examiner		Sequentially list conditions,	Due to (or as a consequence of):			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events	Due to (or as a consequence of):			
9	cate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consequence of):			
3760	certificate inding physuse as the	Medi					
Box 68	to the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending to completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery  Month Day	Year
д О	that the	by Ph	Part II. Other significant conditions cor	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause	e of death?
ds,	quires en sign	ted b			1 □ Yes 2	No 3 Probably	4 🗌 Unknown
ecor.	he law re te has be age 2 sh	Completed			24a. Was an autopsy performed?	24b. Were autopsy find prior to completio death?	n of cause of
<u>a</u>	ian: T irtificat ctor, po		25. Was case referred to medical examiner?	26. Place of Death (Check of	1 Yes 2 Nonly one)	lo 1 Yes 2 🖳 N	lo_
5	hysic his ce Il direc	유	1 🔀 Yes 2 🗌 No		ne 5 Residence 6	6 ☐ Other (Specify)	
on of	ending P aath. or: After t he funera	Certificate:	27. Manner of Death  1	28a. Date of injury (Month, Day, Year)  28b. Time of injury  28c. Injury at work?  1 □ Yes 2 □ No	3d. Describe how injur	y occurred	
Division of Vital Records,	tal or Att rs after d al Direct ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street an City or Town, State	nd Number or Rural Route (	Number,
	ne Hospi in 24 hou ne Funer pleted fill	Medical	(Check 2 ☐ Medical Examination	cian: To the best of my knowledge, death occurred at the time, date and place, and pr: On the basis of examination and/or investigation, in my opinion, death occurred at the Practioner: To the best of my knowledge, death occurred at the time, date and place,	ne time date and place	and due to the cause(s) ar	nd manner stated.
	Voith Com.	— r	29b. Signature and title of certifier	29c. License number 1174781611	29d. Da	ate signed (Month, Day, Yea	
	10/1		0 11/ 0 -	CE SOMBAN STORY		DRE, MD 212	
	Stat	~	31. Date filed (Month, Day, Year)  FEB 1 2 2010	32. Registrer's Signature		, 2616	-01
	Registra		LEGIN COIL CA	way a. Mare			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Thomas Earl Woodfolk February 2010 5:54 P M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1X M 2□ F 224-26-7734 88 June 23, 1921 Virginia Usual Residence of Decedent 10b. County 10c, City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2148 Duckwalk Court 20602 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ 42/2/1942 If Yes, Give 11/2/1943 Year or Dates: 11/2/1943 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Recovery Room Attendant Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward T. Woodfolk Virginia Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Woodfolk 2148 Duckwalk Ct., Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 2/13/2010 Oakwood Cemetery Charlottesville, VA 21. Signature of Funeral Service Linens 22. Name and Address of Facility
J.F. Bell Funeral Home, Inc. 108 Sixth St., N.W. Charlottesville, VA 22903 Mun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute myocardial disease or condition resulting in death) Hours Due to (or as a consequence of): HEAR Coronary Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 CEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

attending physician for use as the buria

page 2 should

funeral director,

filled in by

certificate

this

To the Hospital or Attendiwithin 24 hours after death.

To the Funeral Director: A

Physician/Medical

Be Completed by

Medical Certification: To

Department of H Important; If ite any injury or ot

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Director

Funeral

þ

Completed

ed other than "natural", or items 23a or 28a-f shore event, the Medical Experiment must be notified at

within 72 hours after

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "ary or other traumatic event, "ha."

Saltimore, Maryland 21215-0036

P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be

Division of Vital Records,

Sequendary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans

IF FEMALE:

Dementia 25. Was case referred to medical examiner?

1 Inpatient 2XER/Outpatient 3 ☐ DOA

autopsy perform 1 ☐ Yes 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes

1 ☐ Yes 2 🗙 No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 6 ☐ Could not be

28c. Injury at Work? 28b. Time of 1 ☐Yes 2 ☐No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24a. Was an

3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

and manner stated,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Accident

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year) 05 am

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Schalger, MD 8924 Chesapeake Ave., North Beach, MD 20714

State Registrar

			ificate of Death	Reg No 2010 0348
Physicia ical Examir	an/	Decedent's Name (First, Middle,Last)     Jason Robert	Wehmer	2. Date of Death Month Day Year January 27, 2010  3. Time of Death 1235 hrs
oui Exami		4a Facility Name (if not institution, give street and number) 1008 Beards Hill Road Room 110	4b. City, Town, or Location of De Aberdeen	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 215-15-1175 1 M 2 F 26	t birthday) If Under 1 Year If Under 24	
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, To	own or Location	10d. Inside City Limit
	ē	MD Cecil	North Ea	
ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number  6 Walden Court	10f. Zip Code 21901	10g. Citizen of What Country? United States
h with t ems 23a t be not	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	( Specify Yes or No- 14. Race - American Indian, Black,
and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	<u>۾</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: White of work done 16b. Kind of Business/Industry
ld be filed within 72 hours after dental Hygiene. aarked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12)  12 Years  College (1-4 or 5+) 1 Year	during most of working life. DO NOT use Full Time Student	retired)
d be filed w iental Hygie arked othe	a	17. Father's Name (First, Middle, Last)  Jeffrey L. Wehmer	Sus	ame (First, Middle, Maiden Surname)
2 should the and M 27 is m umatic of	٩	19a. Informant's Name/Relationship (Type, Print) Mrs. Susan M Matkins (Mother)		or Rural Route Number, City or Town, State, Zip Code) th East, Maryland 21901
permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Mediujury or other traumatic event,		1 X Burial 2 Cremation 3 Removal from State cre	ace of Disposition (Name of cemetery, ematory or other place)  VnSyille Cemetery	Date 20c Location - City or Town, State 2/16/2010 Crownsville, MD
permit. Departm Imports injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral	Home of Dundalk, Inc.
ysician kaminer	9	23a. Part I. Enter the disease, or complications that caused the death. D failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Methadone into Due to (or as a consequence of):		c or respiratory arrest, shock, or heart Approximate Interv Between Onset ar Death
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that uniteted events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):		
oe execute ician and irial - tran	Medical E	d.  AMENDED 23a,27,28	Ba-f,permE, g901 3.3.	10 TT
ath certific attending p	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown	ncy 2 Fetal death 3 Ectopic prec	23d. Date of delivery
ries that the de signed by the be detached f	ģ	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
The law requir sate has been s age 2 should l	Completed			24a. Was an autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician: The	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FI	26.Place of Death (Cher	
ing Phys After this funeral di	۲ 1	27. Manner of Death  28a. Date of Injury (Month, Day Year)	R/Outpatient 3 DOA Other   Nur 8b. Time of Injury   28c. Injury at Work?	rsing Home 5 Residence 6 10 Other: Scene 28d. Describe how injury occurred
To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: , completely filled in by the fi	Certification:	Natural  Pending Investigation Suicide  Suicide  Natural  Pending Investigation Suicide  Suic	d 12:20 pm 1 Yes 2 No le, farm, street, factory, office building, etc.	unk  28f. Location (Street and Number or Rural Route Number, Cit or Town, State) 1008 Beards Hill R
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		4 Homicide (Specify) 113 Certifying Physician: To the best of my knowledge, one)  2 Medical Examiner: On the basis of examination and		
To with To t	Medical	29b. Signature and title of certifier	29c License number O.C.M.E.	29d Date signed (Month, Day, Year)  January 28, 2010
	}	30 Name and address of person who completed cause of death (Item 23 Ana Rubio MD. Assistant Medical Examiner 11	Jaa) 11 Penn Street, Baltimore, MD 212	201
Sta Regista	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 /	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03484 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1:30\_P Dorothy Elizabeth Wesse Medical Feb 3, 2010 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross <u>Burtonsville</u> <u>Montaomery</u> Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year 4 Hrs Min, 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Months Hours (Month, Day, Year) Director 212-12-0673 Jun 13, 1920 Usual Residence of Deceden 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified 1 🗆 Yes 2 No Montgomery Burtonsville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 3415 Greencastle Rd. 20866 12. Was Decedent Ever in U.S Armed Forces?/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) þ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. Charles W. Latleif Claudia G. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Cunningham daughter 10346 Scaggsville Rd, Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 
Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Feb 09, 2010 St. Paul's Lutheran Cemetery Fuiton, MD Signature of Funeral Service icehsee 22. Name and Address of Facility 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ULMONARY EMBOLISM disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER CHRONIC ATRIAL FIBRILLATION 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an has autopsy this certificate 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 D Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0052861

DHMH 17 Rev 7/2009

State

Registrar

GEORGIA AVENUE, SILVER SPRING

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801,

32. Registrar's

VALI

FEB 1 2 2010

31. Date filed (Month, Day, Year)

2010

MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day REC 2010 e /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Randlestown NorthWest Hospital Hospice If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2√□ F 82 212-36-5734 7/6/27 Director SC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Director Windsor Mill 1 □Yes 24 □No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7103 Bexhill Road items 23a 21244 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2√€ No Specify: þ 3 XWidowed 4 ☐ Divorced American Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It is Instituted. Elementary/Secondary (0-12) College (1-4or 5+) Tobacco Laborer 9th 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Jake Martin Roselee Hutchinson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Crawford/Daughter 7103 Bexhill Rd, Windsor Hill, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent Cremator 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation \_3 Removal from State 2/12/10 Hanover, MD Crematory 5 Other (Specify) 4 Donation 22. Name and Address of Facility Hari P. 21. Signature of Funeral Service Lice Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical attending IF FEMALE Se 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy Hospital or Attending Physician: The perform 1 ☐ Yes 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 28a. Date of Injury (Month, Pay) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes investigation 2 🗌 No after death Director: filled in by the Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician AROLIN AKASKI 1210 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7713 Sassafrass Way Severn Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1□M 2€F Months Days Hours Year) Director 234-66-1939 67 Yrs Dec. 17 1942 Usual Residence of Decedent purmit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland D-partment of Health and Mental Hygiene. Inhortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be writtened on. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Virginia Prince William 1 ☐ Yes 2 ☑ No Woodbridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 E. Street 22192 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐Yes 2 ☑No If Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 🔀 No Specify White Specify 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Household 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Raymond Zakaski Audrey Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitchell Scott White (friend) 11381 Morla Lane, Nokesville, VA 20181 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Feb. AAA Crematory 4 ☐ Donation 5 ☐ Other (Specify) Woodbridge, Virginia 2010 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the distasse, or complications that collect the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BREAST resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) the Yes 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page autopsy After this certificate I funeral director, page performed' 1 □ Yes 2 □ 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Seeding 1) မ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 2 Accident 1 ☐Yes 2 ☐No 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed quise of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

DEFENSE HIGHWAY ANNA ADLIM DUYO,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 21, 2010 Рм Dorothy 2:55 Bley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖺 F Months Days Hours Min Apr. 23, 1922 213-18-8457 87 Maryland Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injuy or other traunatic event, the Medical Examiner must be notitified at any injuy or other traunatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Md. Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9507 Veirs Drive #1 20850 USA 11 Marital Status 12. Was Decedent Ever in LLS. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Year or Dates. 1944-46 Specify: 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Claude Buckingham Odie L. Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Robert A. Bley Husband 9507 #1 Veirs Dr., Rockville, Md. 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 1/23/2010Alexandria, Va. 22. Name and Address of Facility 2222-Wisconsin Ave., NW Signature of Funeral Service Lice 101 Hysong 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one complete the complete shock. vors that ca the death. Do not enter the mode of Jying, such as Approximate Interval Between on ead Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Unknown Year signed by the a ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ᅌ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 1 Natural
2 Accident
3 Suicide 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 16 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles 9701-Veirs Dr., Rockville, Md. 208/50 W. Karesh, MD JAN 2 6 2010 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elayne Mayo Bundy January 20, 2010 Year 1:55 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Chevy Chase Chevy Chase Mon toomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 P Months Days Hours Min. Sept. 10, Year 1922 193-18-9764 87 Director Pennsylvania Usual Residence of Decedent or 28a-f show notified at 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 1131 University Blvd. West, #1222 20902 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည should be Burton E. Mayo, Sr. Alma Pryor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 Dunstable Road, Cambridge, MA 02138 Agnes Bundy Scanlan/Daughter Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory Jan. Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any Injury or o ŏ 1 Burial 2017 Cremation 3 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signatury of Juneral Service Licen Francis J. Colfins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or acause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lilled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 **D**No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 Ao 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 1 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **%**No မ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ma, us 00057124

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 22 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Truong Bao, MD 10110 Molecular Drive, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per phys. G900 2/9/10 dk. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year William Hugh Bromwell Jan<u>uary</u> /Medical 2010 1258 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital EIKTON

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, DEC 2, | DEC 2, | Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 X M 2 □ F Months Yrs. Director 148-42-1064 59 1950 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, it is Modical Examination and interest and any or other traumatic event, it is Modical Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Ceci1 Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 430 Hazelmoor Drive 21919 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ð 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Civilian Machinist United States Navy 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Bromwell ဥ Catherine Murry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Bromwell, Jr./Cousin 301 Hazelmoor Drive, Earleville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State January R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 27, 2010 West Chester, PA 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final SEPTIC **Physician** SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ERITONI Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed CIRRHOSIS OF LIVER attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a 5 ☐ Other (specify) 9 Unknown HX & Records, F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ HYPERTEMSION director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed HEPATO RENAL SYNDROME 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an certificate has Division of Vital 1 □ Yes 2 🙀 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: npletely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ↑ McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) within 2 To the the 29b. Signature and title of certifier ပ 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar TANMAY

31. Date filed (Month, Day, real)

KTON MD2

106 BOW STREET
Pregistrals Signature

mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMANT

23/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State 2-1-10
Registrar Amend#'s10c.19a.19b.PerfhPccCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ W. 5:20 PM James Daniels January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 10/2/1944 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 **Funeral**  Birthplace (State or Foreign Country) 1 🙀 M 2 🗆 F Months Days Hours Min. 578-60-2942 Director 65 South Carolina Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location
Upper Marlboro 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1206 Shell Duck Ct. 20774 US hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afti.
Department of Heath and Mehalel Hyglens, Immortant: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wesley Daniels Mary Singletary 19a. Informant's Name/Relationship (Two) figure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Upper Mariboro
1206 Shell Duck Ct. Mitchellville, MD. 20 Karen Daniels / Daughter 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 😾 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Fort Lincoln 1/30/2010 Brentwood, MD. Funeral Sarvious 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature rances 23a. Part 1. Enter the dise se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failu'e. Ist only one cause on each line. 3401 Bladensburg Rd. Brentwood, MD. 20722 Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Malignancy disease or condition Medical resulting in death) Examiner Metastasis to brain with brain edema Sequentially list conditions, if any leading to include cause. Enter Underlying Diserto for es a consequence off Examin or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Other (specify) Month Year Pregnant at time of death Day 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: hours after death.

neral Director; After this of filled in by the funeral dire 1 🗌 Yes 2 🔀 No ပု 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral D Hospital Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00069835 Sangutha.R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Sangeetha Ranganath, MD

1500 Forest Glen Rd., Silver Spring, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03491 Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month JAC. JAN.31,2010 2:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GENESIS LA PLATA CENTER LA PLATA CHARLES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-9-1918 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months NEW YORK 1 □ M 2 👽 F 063-12-4352 91 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show aumatic event, the Widhall Evaninar in ust be notified at MD. CHARLES Director LA PLATA 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 1 MAGNOLIA DRIVE by Funeral 20646 within 72 hours after death \_ A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NAVAL OCEANOGRAPHIC Elementary/Secondary (0-12) College (1-4or 5+) CARTOGRAPHER OFFICE 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev JOSEPH HANRATTY 2 ALPHONSENE QUAVE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH FARRELL-DAUGHTER 12<u>705</u> AMBERLEIGH\_LN. LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Departion 3 Removal from State METROPOLITAN CREMATORY 2-2-2010 ALEX., VA. 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Her the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NGESTIU disease or condition resulting in death) MUNTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and Due to (or as a consequence of): burial Box 68760, physician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy Physician: The perform certificate Division of Vital 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) dire 1 Yes 2. No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 XNatural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie

State Registrar RICHARD

31. Date filed (Month, Day, Year,

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FERRY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FONVILLE Physician/ 0843 M Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death ecurity Number 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year North Careling Director Usual Residence of Decedent al Hygiene. I other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director Sb Vert 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2065 Nuet 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) lanage Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ pe permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic to 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pript) DRAILE M. FONVIlle Daunter aven Rd TempleHills,MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 29-200 Bladeusburg INCOLN 4 Dopation 5 Other (Specify) Signature o 22. Name and Address of Facility Wiseman Funeral amospillmis MD 60746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SLAG disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Box 68760 as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy
 Other (specify) \_\_\_\_\_\_ Į0 in the past 12 months? Month Day Pregnant at time of death 2 No the page 2 should be detached g Unknown 9 Unknown P.O. ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Funeral Director: After this certificate sted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: MANDARIN ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) HOUSE Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Alatural
2 Accident
3 Suicide
4 Homicide 5 Pending death. 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Norse Prantianer: To the kest of my linewisdge, deets on the only one at the thire, date and pla and title of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death KAN 31. Date filed (Month, Day, Year) JAN 2 6 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year zomines rowell 01 /Medical 2010 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country)
NORTH CAROLINA **Funeral** 7. Age (In vrs. last b 8. Date of Birth (Month, Day, Year) Months Days Hours **Ж**□ M 2 □ F Director 577-42-4547 8/13/1932 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evaning must be rediffed at anones. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S OXON HILL 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2124 ALICE AVE 20745 UNITED STATES Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 H No BLACK Specify: ģ 3 ☐ Widowed 4 ♥ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GENERAL MANAGER 12th PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be QUENNIE ANDREWS PAUL GRIMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLSWORTH GRIMES JR. / SON 2124 ALICE AVE #2 OXON HILL, MD. 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 2/1/10 BELTSVILLE, MD. 4 Donation 5 ☐ Other (Specify) Funeral Service Ligensee 20002 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., DC 23a. Part 1. Enter the disease shock, or heart failure. I omplications that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🛂 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and (Ne of certifier 29d. Date signed (Month, Day, Year) 1-22-2010D 51520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern AVE SE WASHINGTON De DISHDAD MD 1328

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State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 26 per phys. G900 2/9/I0 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LILLIAN VICTORIA GOSS JAN 12,2010 2:49A /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 2250 BLANCHARD PLACE BRYANS ROAD CHARLES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 - 9 - 1921 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours WASH., D.C. 88 579-20-0772 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location works 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, "14 "14 "15 delle st. miner must be notified at Director MD. CHARLES 1 ☐Yes 2 No WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 1042 BANNISTER CIRCLE Funeral 20602 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: ģ Specify: BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) G.S.A. U.S.GOVT. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other thin any Injury or other trailmastic. SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN BLAKE LENA THOMAS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADRIENNE BROWN-DAUGHTER 1042 BANNISTER CIRCLE WALDORF, MD. 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cernetery, Crematory of Ourier Praces
4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDENS 1-16-2010WALDORF, MD. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646, 21. Signature of Funeral Service Licensee MD0479 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** ces disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 06 Sequentially list conditions, and leaf cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): # 74,/0€ 426 Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed certificate 2 No Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Caregiver's Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010 egistra Signature

Moura

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan. 22<sup>ay</sup> 2010 0709 Billy Ho1t Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Hours New Yrs. Director Jan. 110-48-8910 53 York Usual Residence of Decedent "natural", or items 23a or 28a-f shov adical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 533 Red Coat Place 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 🖾 No Specify. Specify: 3 Widowed 4 X Divorced Completed Year or Dates American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' ury or other traumatic event, the Me Elementary/Seconday (0-12) 12th College (1-4 or 5+) Sanitation Worker Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Holt Vivian Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 Red Coat Place Fort Washington, Md. Shanel Hackett/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Greenfield Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Hempstead, NY 22. Name and Address of Facility Stewart Funeral Home, Inc. f Funeral Service Lice . Si 4001 Benning Rd. NE Washington, DC 20019 23a. Par 1. Dater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to or as a consequence of): Examiner Metastatic Sarcoma Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an has page 2 performed? Yes 2 K N certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No 1 Tes Certificate: To 1 Marient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurea Fractioners To the best of my knowledge, death concurred at the three date and plane, and due to the names(ii) and marrier as stat-29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0052586 22/2010

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Registrar

DHMH 17 Rev 7/2009

. Date filed (Month, Day, Yéar)

JAN 2 6 2010

20910

Silver Spring, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jayanti Patel M.D. 1500 Forest Glen Rd. Physician /Medical Examiner

sician and burial-transit

the attending physician

as the

detached signed by

Hospital or Attending Physician: The law requires that the death certificate be executed

After this

within 24 hours after death To the Funeral Director: completely filled in by the

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

Be

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**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exaction or items 200.

Examine ۾ Be Certification: To

Physician/Medical Completed

29a Certifier

(Check only one)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

examiner? .										
1 Yes 2 No	Hospital:	1 Inpatient 2	BR/Outpatient	3 🗆 D	Other:	4 ☐ Nursing H	ome	5 Residence	6 ☐Other	(Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigatio		Date of Injury (Month, Day, Year)	28b. Time of Injury	м	28c. Injury at Work? 1 □ Yes	2 □No	28d.	Describe how inju	ury occurred	

3 ☐ Suicide 6 Could not be 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the dasks of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signat	ture and title of certifier	a m
	1 evit	WIND

29c. License number 0282811 29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELSON BENJERS, 9131 PISCOT WAYP, CLINFON 31. Date filed (Month, Day, Year) 32. Red

State Registrar

Medical

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03497 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Benedict Elder Holohan 6:50 P M 2010 <u>January</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) ine 26,1930 1 X M 2 □ F Days Hours Columbia Columbia 79 Yrs **Director** 578**–**38–4748 June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Manassas City Manassas Virginia 1 Tes 2 X No  $\bar{\Box}$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9715 Loudoun Avenue 20109 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 X Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic mans in market and the strain or other traumatic mans in mans i Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Shoes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elder Benedict Holohan Mary Ellen Kenny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Holohan/ Brother 9715 Loudoun Avenue, Manassas, VA 20109 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State January 22 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) exandria, VA 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licenses M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metabolic Alkalosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Acute Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Dehydration that initiated events resulting in death) Last Due to (or as a consequence of): -burial physician the burial Physician/Medical Pneumonia that the death certificate be attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ The law requires Hematurie 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypernatremia autopsy perform Yes 2 X No 1 Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 No ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the 29b. Signature and title of of tifier 29c. License number 29d. Date signed (Month. Day. Year) D55148

Registrar

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Baltimore, Maryland 21215-0036

68760

Box

P.0.

Records,

**Division of Vital** 

State

1500 Forest Glen Road, Silver Spring , MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

Registrar's Sign

Delroy Anglin M.D.,

31. Date filed (Month, Day Ye

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

1. Decedent's Name (First, Middle  Mary R  4a. Facility Name (if not institution,  Gilchrist Ce: 5. Social Security Number  217–46–9806  Usual Residence of Decedent	egina Hov						2. Date of De		- U	. 0	3. Time of Death
4a. Facility Name (if not institution, Gilchrist Ce: 5. Social Security Number 217–46–9806		700					Janua:	77 Da	5, 20	rear 17	1:05 A M
Gilchrist Ce: 5. Social Security Number 217-46-9806				4b. City, Town, o	or Location	of Death	Janua.	Ť	. County o		
5. Social Security Number 217–46–9806					wson			,,,		_	imore
	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir				place (State or Foreign
Usual Residence of Decedent	1  M 2 <b>X</b> F	64	Yrs.	World 3 Days	Tiodis	I (VIIII)	Mar 1	0, 1	945	Was	hington, DC
10a. State 10b. County		10c. City	y, Town or Lo	cation						T	10d. Inside City Limits
Maryland Howa	rd			Laurel							1 🗌 Yes 2 🙀 No
10e. Street and Number	La			10f. Zip Code				10g. Ci	itizen of Wh	at Cou	intry?
9426 Woodsong Court				20	723			Uı	nited	Sta	ates
	Armed Fo		5. 13.	Was Decedent of I f Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)				
	If Yes, Giv	е		1 ☐ Yes 2 🔀 No	Specify.	:			Specify:	,	White
15. Deceder	nt's Education	ites.	16a. Dece	dent's Usual Occu	pation			16b. K	Kind of Bus	iness In	ndustry
		-4 or 5+)	(Give life. D	kind of work done O NOT use retired	<i>during m</i> os )	t of workir	f working				
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									arrsv		Approximate
Immediate Cause (Final disease or condition	nly one cause on ea	ch line.	cell C	arcino	na o	F Vo	seing				Interval Between Onset and Death
	Due to (	or as a consequ					9				
if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury											
that initiated events resulting in death) Last											
	d										
23b. Was decedent pregnant	23c. If yes, out	come of pregna	ncy Ideath 3 F	Ectopic pregnan	CV				23d. Date	of deliv	very
in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown	4 🗌 Preg	nant at time of d							Monti	h 	Day Year
Part II. Other significant condition	ns contributing to d	eath but not res	ulting in the u	nderlying cause 9	ven in Part	I.	23e. Did t	obacco u	use contrib	ute to ti	he cause of death?
							1 🗆	Yes 2	□ No 3	☐ Pro	bably 4 🕅 Unknown
									24b. We	ere auto	opsy findings available empletion of cause of
								ormed?	de	ath?	•
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1 Yes 2 No	1 🗆			it 3 L DOA	4 ∐ N				_	(Specify	n hospile
1 Matural 5 ☐ Pendin 2 ☐ Accident ☐ Investig	g (Mont	of injury h, Day, Year)	injury	wor	k?	28d. Describe how injury occurred					
		eet, factory, office	ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)				l Route Number,				
(Check 2 Medical E	xaminer: On the bas	is of examination	and/or invest	tigation, in my opin	on, death of	courred at	the time, date a	and place	e, and due to	o the ca	ause(s) and manner stated.
	1			29c, Licens	e number			29d. Dat	te signed (/	Month,	Day, Year)
30. Name and address of person s	who completed caus	e of death (Item	23a) (Type F	Print)	583	503		اجل	Nrev	7	25 2010
	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  15. Deceder (Specify only highe Elementary/Seconday (0-12)  12  17. Father's Name (First, Middle, L Melvin Her.  19a. Informant's Name/Relationst Eileen Howes/s  20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (S)  21. Signature of Funeral Service L  23a. Part Enter the disease, or shock, or heart failure. List of the cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1  Yes 2  No 27. Manner of Death 1  Naccident   Prevention of Could determ  29a. Certifier   Certifying Cause (Diseased of Could determ)  29a. Certifier   Certifying Cause (Diseased of Could determ)  29b. Signature and title of certifier  29a. Certifier   Certifying Cause (Diseased of Could determ)  29b. Signature and title of certifier	11. Marital Status 1	11. Marital Status  1	11. Marital Status    Never Married 2   Married   12. Was Decedent Ever in U.S. Armed Forces?   13.   13.   13.   14.   15. Decedent's Education   15. Decedent's Education   15. Decedent's Education   15. Decedent's Education   16. Decedent's Education   15. Decedent's Education   16. Deced	11. Marital Status	11. Marital Status 1   Newer Married 2   Married   1   Archard Forces?   1   Yes 2   2   No   1   Yes 2   2   No   1   Yes 2   2   No   1   Yes 2   2   No   1   Yes 2   2   No   1   Yes 2   2   No   Year or Dates.  1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 1   Speeding only highest grade completed) 2   Speeding only highest grade completed) 2   Speeding only highest grade completed) 2   Speeding only highest grade completed) 2   Speeding only highest grade completed (Sive Red and Numb grade) 2   Speeding only highest grade completed (Sive Red and Numb grade) 2   Speeding only highest grade g	11. Martial Status 1   Never Married 2   Married 1   12. Wisa Decedent to the form in U.S. 1   1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   St. No 1   Ves 2   Ve	11. Marital Status	11. Marital Status	11. Marital Status   12. Was Decedant Ever in U.S.   13. Was Decedant of Hispanic Origin? (Spordy, Year or No.   14. Piscet.   14. Piscet.   15. Decedent by Spordy   15.	11. Martial Statius   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   12. Was Discodent Ferri nu U.S. Argined Force   13. Most Provided Martin Number of Providing Mile Do NoT use retired   14. De No No use retired   15. Most Providing Martin Number of Prov

State Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Wayne Holland Month Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 12/31/1 **Funeral** 9. Birthplace (State or Foreign 214-34-7433 1 🕱 M 2 🗆 F Months Days Hours Min. 72 Director Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho all yilury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1517 Lavale Terrace 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 If Yes, Give Army Year or Dates Army 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Specify. white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Holland Evelyn Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Lavale Terrace, Salisbury, MD 21804 Deanna F. Holland/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicemeters cremative or other place Park Memorial 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 1/25/10 Salisbury, MD Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 CFSP House Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence on Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events 45 WM 541015 ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2.s. performed? 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 은 1XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural Accident injury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Nah 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

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DR. USIHA NATESAN

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egistrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO 57359

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 Day **Physician** 2010 1148 Yvonne M. Henry Jan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 221-22-9615 Feb 4, 1937 DE Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a, State show Examiner must be notified at Berlin 1 Yes 2 No Director MD Worcester 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Items 23a 308 Flower Street 21811 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. D. O.B. 02 - 04 - 1937 D.O.D. 01 - 17 - 2010 Iltimore, Maryland 21215-0036 1 Never Married 2 ☐ Married "natural", or African-If Yes, Give Year or Dates: 1 Tyes 2 TNo Specify <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced American Completed is marked other than "natur aumatic event, it e l'exical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Non-Profit Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joshua Henry Hattie Smack ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Kevin Henry/son 308 Flower Street, Berlin, MD 21811 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 101/23/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA Bal Wasson 1618 West Road, Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Corenny Artery Disease
Due to (or as a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy 5 ☐ Other (specify) page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 Pulmonary 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 No 2 🗆 No Division of Vital Hospital or Attending Physician: 24 hours after death. director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🖾 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Dr. Jane Crick DO045995 /22/10 all luch No

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DHMH 17 Rev 1/2001

State Registrar Salisburn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

560 Riverside Dr. 31. Date filed (Month, Day, Year)

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